OHA Review of 2023 CCO Transformation and Quality Strategy (TQS)
AllCare CCO

Overview

Scoring process

OHA subject matter experts reviewed each project against the TQS guidance document for each component assigned to that project.

- Reviewers assigned a separate score of 0–3 for relevance, detail and feasibility.
- Relevance scores of zero mean the project did not meet the component-specific requirements; for these projects, detail and feasibility will automatically also score a zero.
- Relevance, detail and feasibility scores were summed for a total possible component score of 9.
- If a CCO submitted multiple projects for a component, scores were averaged to create a final component score.

How scores will be used

CCO scores will provide OHA with a snapshot of how well CCOs are doing in component areas. The scores will help OHA see what improvement is happening and identify areas of technical assistance needed across CCOs. Individual CCO scores and written assessments will be posted online.

How to use this feedback

CCOs should use this assessment to update TQS projects for 2024 TQS submissions to ensure quality for members, while also continuing to push health system transformation to reduce health disparities across the CCO's service area.

Background

As part of a CCO quality program, the TQS includes health system transformation activities along with quality activities to drive toward the triple aim: better health, better care and lower cost. As part of 438.330 CFR, Quality Assessment Performance Improvement (QAPI), CCOs will submit the annual look-back across TQS components and provide analysis with a plan (that is, a TQS project) to improve each component area. The TQS highlights specific work a CCO plans to do in the coming year for the quality and transformation components. It is not a full catalog of the CCO's body of work addressing each component or full representation of the overall quality program a CCO should have in place.

Next steps

1. **Schedule a feedback call with OHA** – OHA is requiring each CCO to participate in a feedback call. Please fill out the scheduling form at https://www.surveymonkey.com/r/D5B6VVG. During the call, OHA will walk through this written assessment and answer any questions. Calls are available in June–August.
2. **If needed, send a redacted version (with redaction log)** to cco.mcodeliverablereports@odhsoha.oregon.gov

Notes:

- **Resubmissions** – OHA will not be accepting resubmissions. This helps ensure transparency across the original TQS submission and resulting written assessment. Feedback from the written assessment and feedback calls are intended to help CCOs focus on ways to improve projects and documentation in future submissions.
- **What will be posted** – OHA will post each CCO's entire TQS submission (sections 1, 2 and 3) — or redacted version, if approved by OHA — along with written assessment and scores.

CCO TQS assessment			
Component scores			
Average score	**# of projects**	**Prior year score**	**Component**
8	1	9	Behavioral Health Integration
8	2	9	CLAS Standards
9	1	8	Grievances and Appeals System
9	1	8	Health Equity: Cultural Responsiveness
7.5	2	8.5	Health Equity: Data
8	1	9	Oral Health Integration
9	1	9	Patient-Centered Primary Care Home: Member Enrollment
9	1	9	Patient-Centered Primary Care Home: Tier Advancement
9	1	8	Severe and Persistent Mental Illness
9	1	5.5	Social Determinants of Health & Equity
6	1	6	Special Health Care Needs – Full Benefit Dual Eligible
7	1	0	Special Health Care Needs – Non-dual Medicaid Population
6.3	3	9	Utilization Review (Medicaid Efficiency and Performance Program)
104.8 (out of 117; 89.6%)		**110.5 (out of 144; 76.7%)**	**TOTAL TQS SCORE**

Note: The three access components were removed in 2023, which accounts for the difference in total points possible from 2022.

Quality Assurance and Performance Improvement (QAPI) program attachments	
	Met/not met
QAPI workplan	Met
QAPI impact analysis	Met
OHA feedback: OHA appreciates the comprehensive approach AllCare has taken in making connections across program areas and utilizing data in meaningful ways.	

Project scores and feedback				
Project ID# 412: Increasing engagement of individuals newly diagnosed with a SPMI				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Serious and persistent mental illness	3	3	3	**9**
OHA review: Project meets component requirements. Solid matching with population definitions, national and local data comparison, and use of data and member experience. Thorough review of data to identify population including REALD with plans to incorporate SOGI data, identifying areas of improvement based on findings. A value-based payment methodology is a great strategy; however, the threshold for payment is vague with goals uncertain. Other measures are moderate but feasible. **OHA recommendations**: Would like to see if a 5% increase comprises a significant increase given the population through a t or z score. Clarify VBP goals.				

Project ID# 48: Intervening on Social Determinants of Health of the Special Needs Population				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Social determinants of health & equity	3	3	3	**9**
Special health care needs: Full benefit dual eligible	2	1	3	**6**

OHA review (Social determinants of health & equity): Project aligns well with SDOH-E components; serving high need population that aligns with CCO's REALD data. Stating that data analysis will happen regardless of REALD/SOGI suggests a missed opportunity to see the value in this data. CCO called out specific use of disability data, but what other gaps were identified and could have been accessed within this project? The narrative regarding the data was also unclear. Initially it was stated that the REALD/SOGI sample size was too small, but then CCO did identify REALD data for race, disability and language. Marked improvement in outcomes. SMART benchmarks are easily tracked.

(Special health care needs: Full benefit dual eligible): Project focuses on a high-risk population and has potential to reduce morbidity and mortality. CCO persevered in partnership even with significant changes at partnership organization. Project has created measurable long-term objectives and saw some improvement for participants in the previous pilot year despite issues with the partner.

Project doesn't fully address last year's feedback about not clearly meeting all the SHCN criteria for identifying and monitoring health outcomes, especially #3 (project primarily focuses on quality improvements related to improving health outcomes for your identified SHCN population) and #4 (project clearly identifies and monitors health outcomes for your identified SHCN population). It's also unclear what the Medicaid Advantage plan's role is in this work (no clear discussion of DSNP plan).

Project is feasible, particularly if CCO adds short-term health monitoring tracking measures (see suggestions below) to bring project to a more complete approach for FBDE SCHN population.

OHA recommendations (Social determinants of health & equity): Consider opportunities to take a deeper dive into SDOH-E and mitigating other contributing factors to falls. Questions within the assessment include medication, but it's unclear what is done with that information. Clarify intention and plan for using REALD.

(Special health care needs: Full benefit dual eligible): Project can better align with SHCN requirements by monitoring health issues potentially contributing to falls risk, such as polypharmacy, blood pressure, blood glucose, etc. For SCHN requirements, projects need to not just monitor long-term health impacts (like ED use and fall rate). This feedback was provided last year, and the only addition is MTM program link. Project should also link the MTM metrics, such as medication reconciliations, medication refills and MTM program participation by REALD. Was drop-out rate looked at more closely? Perhaps follow-up interviews could inform undiagnosed barriers. It's unclear how the project disparity data compares to the larger disability population, which the project indicates it hopes to better assist. Consider looking at how members are notified of opportunities to participate and if engagement materials are available to the population of focus (for example, specific Latino outreach materials). Is there opportunity to connect to other SDOH needs (Meals on wheels, etc.)?

Are the THWs also qualified or certified interpreters? Project needs to comply with CLAS requirements for language access. Dual certification as interpreters is necessary if the THWs are interpreting at medical appointments.

Consider looking at falls prevention programs or referrals to physical therapy for balance assessments and therapeutic activities to reduce falls. Perhaps more is being done by CCO than is clear in project submission.

The number of duals served was quite low. Should plan go upstream to provide assessments to prevent those initial falls for more at-risk population? HERC approved falls prevention programs that some regions even provide in-home to members.

Project ID# NEW: Continuous Glucose Monitor expansion / increased diabetic oral health care

Component	Relevance score	Detail score	Feasibility score	Combined score
Special health care needs: Non-dual Medicaid population	2	2	3	**7**

OHA review: Project is targeting a high-need population with critical supports. A deeper dive into CCO activities to improve health is required per criteria #3 and #4 for SCHN projects (3: project primarily focuses on quality improvements related to improving health outcomes for your identified SHCN population and 4: project clearly identifies and monitors health outcomes for your identified SHCN population). The role for DSNP is also unclear (criteria #5). Monitoring activities don't include REALD/SOGI review to determine disparities, though narrative includes initial analysis. Need to ensure equity in access to these types of care.

Project is feasible, but it will not adequately monitor health progress and meet the SHCN requirements without additional monitoring activities such as ED use or reductions in population A1C. It's possible that CCO is doing some of this but hasn't included these in project monitoring activities.

OHA recommendations: Identify longer-term health improvement metrics (for example, reduce ED use). Also include shorter-term health outcome monitoring activities (for example, treatment plans, medication refills or A1C testing at PCP twice per year). Note the difference between collecting A1C for MEPP cost-reduction and ensuring overall improved care outcomes for all with diabetes. Consider ensuring these members get diabetes self-management programs.

Add REALD/SOGI review to monitoring activities to identify disparities. Project identified that very few Latino and Native American members are in the population group. How did that initial analysis inform the project? Is disparity because of a lack of knowledge about availability of continuous glucose monitoring or more uncontrolled/undiagnosed and tested populations? Are all members' claims review used for identifying them into the diabetes SHCN population? What is the relationship of the overall diabetic population to the CGM population? Perhaps more culturally specific outreach strategies needed for engagement.

Project ID# 56: Health Equity, African American PCP visits

Component	Relevance score	Detail score	Feasibility score	Combined score
CLAS standards	3	3	3	**9**
Health equity: Cultural responsiveness	3	3	3	**9**
Health equity: Data	3	3	3	**9**

OHA review (CLAS standards): This project meets CLAS Standard 11's purpose to accurately identify population groups within a service area — in this instance down to zip code. It also does an excellent job of working toward improving service planning to enhance access and coordination of care. The details

demonstrate good utilization of REALD, and there is an indication that SOGI will be considered once that data is available. Activities directly relate to the CLAS component and standard #11.

(Health equity: Cultural responsiveness): The CCO provides appropriate level of background and context. OHA appreciates the depth of the analysis on how systemic and institutional barriers have a role in the inequities experienced by this particular population.

(Health equity: Data): The CCO shares an appropriate level of detail and addresses systemic barriers for health equity.

OHA recommendations: None.

Project ID# 413: Education on the Appeals and Grievance Process for Targeted Patient Populations				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Grievance and appeal system	3	3	3	**9**

OHA review: Project meets the requirements for this component. The CCO included data for both grievances and appeals that very clearly shows there is not much diversity in who is submitting G & As. Activities show CCO is working toward understanding what they need to do to increase member knowledge of G & As.

OHA recommendations: None.

Project ID# 54: Patient-Centered Primary Care Home (PCPCH)				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
PCPCH: Member enrollment	3	3	3	**9**
PCPCH: Tier advancement	3	3	3	**9**

OHA review (PCPCH: Member enrollment): Excellent list of detailed activities to increase member enrollment. Project context, previous year of barriers due to pandemic, and details of activities to achieve TQS goals are clearly outlined. Technical assistance projects and activities directly align with desired target and benchmark outcomes. Project is feasible as described.

(PCPCH: Tier advancement): Project describes comprehensive plan to support PCPCH practices in upward tier recognition. CCO did an excellent job of detailing the barriers they have faced as a result of the pandemic and their plan to move forward to assist practices in upward PCPCH tier recognition. Activities were clearly laid out as SMART goals. The activities are measurable and thoughtfully detailed. Based on the context provided, the activities seem feasible.

OHA recommendations: None.

Project ID# NEW: MEPP - Addressing Pediatric Asthma in AllCare members				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Utilization review	2	2	2	**6**

OHA review: Project is missing description of CCO's overarching UR strategy. Consequently, the CCO did not demonstrate that the project is the result of the CCO's broader monitoring activities, nor does it effectively demonstrate the CCO's ability to detect over/under utilization.

The patient experience anecdotes were effective in demonstrating the connection to quality of care. Detail regarding the target population and penetration rates was well documented.

The CCO did not use the TQS format properly within utilization review projects, but they did cover all the content across utilization review projects. Section E, for example, should be a brief narrative about the project and not a brief overview of the implications of the disease state. Section C was missing the overall utilization review strategy. The CCO did include more information on the overall UR process as part of the CGM expansion project.

Monitoring measure 1.1 is unclear. The baseline lists a population count, the target is a 5% improvement, and the future benchmark is an adherence rate target.

OHA recommendations: Stick to the TQS template format so reviewers know where to find the information they need. Content like the component prior year assessment can be repeated across utilization review projects if needed. Revise monitoring measure 1.1 to improve clarity and keep the performance statistic consistent over time (can add a new monitoring measure if trying to measure two separate things). For monitoring activity 3, total spend may not be the best measure of performance improvement because total caseload could increase resulting in an increase in costs that makes it hard to see the effect of the intervention. Consider revising to a cost per member per month or per year to account for changes in caseload. Additionally, the description includes collecting three types of utilization data, yet the monitoring activity is only on ED. Is this intentional?

Project ID# 50: MEPP - CGM expansion to address under utilization

Component	Relevance score	Detail score	Feasibility score	Combined score
Utilization review	3	2	3	**8**

OHA review: The CCO provided numerous types of analysis that clearly demonstrate the CCO's ability to evaluate utilization patterns over time, including comparing utilization patterns across cohorts to gain insights. Additional context around the CCO's overall UR strategy would be useful. The component requires an assessment of prior year performance for the overall component, not just the project-specific activities. The population comparisons provided useful insights on the efficacy of the intervention. Goals are realistic, specific, and demonstrate a well thought out set of both action steps and performance measures.

OHA recommendations: Include a prior year assessment for the overall component (beyond this specific project). Include specific findings and an assessment of the efficacy of the utilization review strategy.

Project ID# 53: Provider Training Program to Increase the use of Medically Certified Interpreters

Component	Relevance score	Detail score	Feasibility score	Combined score
CLAS standards	3	2	2	**7**
Health equity: Data	2	2	2	**6**

OHA review (CLAS standards): Narrative explains the need to continue supporting ASL interpreters in the region, but no specific activities address this need. There is also no mention of integrating VRI as a backup for providers like LanugageLink for spoken languages.

Excellent use of granular REALD data with a comparison to encounter data. Excellent transformative goal of increasing encounters by 5% for Spanish speakers who are currently at 30%. Excellent use of REALD data to identify and address disparities in the context of a CLAS standard — great integration. Positive evolution of Activity #1 from last year. Excellent SMART benchmarks. Monitoring measure 1.1 is an excellent example of how a CLAS standard and REALD data can be used to develop an excellent SMARTIE goal.

Detail score was reduced by 1 point because while this project focuses on spoken language with some focus on ASL and hard of hearing members, it does not provide a full review or mention why the project is excluding a review of SOGI.

(Health equity: Data): The project is appropriate, but description of quality and transformation aspects aren't as clear. Project includes some references to the work on complaints and grievances, but the link isn't as evident to third parties. Monitoring measure 2.1 is appropriate, but it's not clear what aspects of quality and transformation can be gathered from an increase in encounters alone.

The three findings cited in the project context from interviews with community partners could be valuable to share with other CCOs.

OHA recommendations (CLAS standards): The lack of detail in Activity 2 and the monitoring measure are confusing (is the title wrong?). Additional detail is needed to understand how CCO expects to get back to the 2021 baseline. More details needed on how CCO will engage and support the provider network with "reporting fatigue" with regard to interpreter services. Is this occurring across all aspects of provider reporting requirements? Is this barrier specific to interpreter data?

Describe what type of encounter data was used (timeline, visit type, etc.). Include SOGI in analysis and measures.

(Health equity: Data): More clearly point out the quality and transformation aspects of the project. Reference past project activities with results. Clarify goals for monitoring measure 2.1.

Project ID# NEW: MEPP - Addressing compliance with monitoring and medications in adults with hypertension

Component	Relevance score	Detail score	Feasibility score	Combined score
Utilization review	2	2	1	**5**

OHA review: Project is missing information about the CCO's overarching UR strategy. Consequently, the CCO did not demonstrate that the project is the result of the CCO's broader monitoring activities, nor does it effectively demonstrate the CCO's ability to detect over/under utilization. Project is missing an overview of the component.

The CCO did not use the TQS format properly within utilization review projects, but they did cover all the content across utilization review projects. Section E, for example, should be a brief narrative about the

project and not a brief overview of the implications of the disease state. Section C was missing the overall utilization review strategy.

A 25% decrease in hospitalizations and ED does not seem reasonable for 2023.

The narrative notes needing to implement new strategies. While one strategy is noted, it is unclear if that is the only one the CCO will be implementing or if it needs additional strategies to hit the target. If the latter, this should have been done as part of TQS planning with action steps for the additional strategies added.

OHA recommendations: Please stick to the TQS template format so reviewers know where to find information. The component prior year assessment can be repeated across projects if needed.

Consider reformatting tracking metrics to include dates and specific targets rather than "increase of X%". This will aid tracking, particularly when the target has quarterly milestones. Consider updating the tracking metrics, as 2022 should be known values at this point. Baselines for periods prior to 7/1/2022 should have been calculated and included to ensure your target decrease is reasonable.

Consider looking at hypertension-related illnesses vs. only primary diagnosis of hypertension for admissions. MEPP identifies a number of diagnoses that are complications of hypertension. The tool can be used to identify the top complication Dx codes for the episode. Even if tracking utilization outside of the dashboard, the Dx codes could inform the CCO's analysis as the incidences of admissions for high blood pressure will be limited, even for individuals with high enough blood pressure to cause health problems.

Project ID# 55: Support Increased Access to Oral Health Services within a Physical and/or Behavioral Health Setting and Oral Health Referrals to Community Services

Component	Relevance score	Detail score	Feasibility score	Combined score
Behavioral health integration	3	2	3	**8**
Oral health integration	3	2	3	**8**

OHA review (Behavioral health integration): Innovation in using a EPDH and aiming to increase oral services in non-dental settings. Providing presentation on oral health in a SUD residential setting is a great prevention intervention; however, this intervention is missing a monitoring activity.

Insufficient detail in narrative about social needs, main regional drivers and analysis on why uptake of CIE (as measured by lack of referrals) has been low. Reasonable quantitative increases.

(Oral health integration): Project meets OHI requirements. Excellent and detailed background provided for the component prior year assessment. More detail on the use of REALD and SOGI data is needed. The project mentions that SOGI data will be used once available, but does not provide a plan or timeline. Goals for the project appear reasonable and realistic about what can be completed during the measurement period.

OHA recommendations (Behavioral health integration): Add a monitoring activity as described above. Provide more detail about social needs, regional drivers and uptake of CIE.

(Oral health integration): Include REALD in monitoring activities to identify any disparities in project population (follow-ups, referrals, etc.) and address through culturally specific activities if needed. Next year also include SOGI data for identifying and addressing disparities.