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 2023 TQS submissions to ensure quality for members, including access and service utilization, 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

- **Feedback calls with OHA** – OHA strongly recommends that CCOs request a feedback call with OHA by filling out the form at https://app.smartsheet.com/b/form/cea2ff1e021f4558bf053e4829fe3726. During the call, OHA will walk through this written assessment and answer any questions. Calls are available in June and July.
- **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 no sooner than August 1.

CCO TQS assessment			
Component scores			
Average score	**# of projects**	**Prior year score**	**Component**
7	1	7	Access: Cultural Considerations
9	1	8	Access: Quality and Adequacy of Services
8	1	3	Access: Timely
8	1	7	Behavioral Health Integration
3	1	9	CLAS Standards
9	1	9	Grievances and Appeals System
5	1	6	Health Equity: Cultural Responsiveness
7	1	5	Health Equity: Data
9	1	8	Oral Health Integration
4	1	9	Patient-Centered Primary Care Home: Member Enrollment
5	1	9	Patient-Centered Primary Care Home: Tier Advancement
8	1	8	Severe and Persistent Mental Illness
9	1	8	Social Determinants of Health & Equity
0	1	n/a*	Special Health Care Needs – Full Benefit Dual Eligible
8	1	4	Special Health Care Needs – Non-dual Medicaid Population
6	1	7.5	Utilization Review
105 (out of 144; 72.9%)		**107.5 (out of 135; 79.6%)**	**TOTAL TQS SCORE**

* SHCN is now two components. The prior year SHCN projects could have been FBDE or non-FBDE.

Project scores and feedback

Project ID# NEW: Medical Shelter Program				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Special health care needs: Non-dual Medicaid population	3	2	2	**8**

OHA review: Project focuses on high-need population and engages community partner in very meaningful way. Has identified a very high-need focus for the project. Could include more specific measurement/monitoring activities that track health improvement aside from ED use. The project is ambitious and may lose its way without further detailing the specific short-term items it needs to monitor so it can get to its outcomes. It's unclear how project is going to ensure members are receiving treatment mentioned in narrative, such as infusion or cancer treatment, dialysis, home health. Strong partnership, clear need, potential impact on member health is large.

OHA recommendations: Utilization of shelter beds is not an activity that specifically addresses SHCN project requirements (more aligned to access project). For the SHCN population, CCO should consider more short-term health monitoring that would be steps toward meeting goals to reduce ED visits or inpatient stays. Consider adding some interim monitoring — medication refills/adherence; specific sub-population interim

steps for diabetic populations, those with SUD needs; respiratory illness, etc. Having short-term monitoring ensures project is more likely to get to outcomes.

Project ID# NEW: Provider Network Training				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
CLAS standards	1	1	1	**3**

OHA review: The training efforts would cover all CLAS standards, but as described it is not a project that could be considered transformational or focuses on quality because it lacks appropriate objectives. The idea of a training to develop a set of skills could be considered transformative only if the CCO set the appropriate evaluation and follow-ups related to training effectiveness and skill set development. Attendance and course completion rates are not the right measurement for a TQS project. The purpose of the project is unclear from a TQS perspective.

OHA recommendations: This project is not TQS material with the current measurements described (assistance and completion). This project could be transformative and focus on quality if the CCO quantifies the benefits in the acquisition of staff/provider skills and performance and how those can be translated to the provision of culturally and linguistically responsive services.

Project ID# 40: South Coast Together – ACEs Training and Prevention				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Social determinants of health & equity	3	3	3	**9**

OHA review: Established project with strong evidence of working at the community level and collaboration between the health care system and community partners. Some evidence of member engagement through CAC's presumed role in CHP grant funding and feedback (and one consumer member on steering committee). Nice improvement in describing CCO's role in the collaborative. Good use of child health complexity data. Clear connection between monitoring measures and project goals. Continuation of community awareness-building activities while moving deeper into family supports.

OHA recommendations: Could pare down details in project context (summarizing the first few years of the project). Component prior year assessment mostly focused on trauma and ACEs rather than overall SDOH-E component. Consider ways to receive more robust or formalized member feedback, especially on the family support activities.

Project ID# 42: Member Grievance System Improvements				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Grievance and appeal system	3	3	3	**9**
Health equity: Data	3	2	2	**7**

OHA review: (Grievance and appeal system) Good in-depth description of how CCO is reviewing grievance data and where they are seeing gaps in their processes. Project directly relates to the grievance system and should help strengthen grievance system processes.

(Health equity: Data) The CCO is able to produce G&A data by REALD. Project states CCO tracks grievances related to cultural sensitivity by the provider and plan, and it has had no grievances related to cultural sensitivity in the past eight quarters. The lack of G&A may not mean training and other activities are paying off, but rather that G&A systems are not accessible to the member. The activities refer to data collection but includes very little about data analysis. The CCO provides extensive background information and cross-pollination with heath equity plan.

OHA recommendations: (Grievance and appeal system) None.

(Health equity: Data) Incorporate data analysis to ensure this project focuses on quality improvement. The CCO has an opportunity for a deeper dive on what the REALD data is saying or not saying. The current metrics are process focused. Go further to link activities and metrics to quality or transformation. For example, what will happen after the training?

Project ID# 43: Oral Health Integration for Members with Diabetes

Component	Relevance score	Detail score	Feasibility score	Combined score
Oral health integration	3	3	3	**9**
Utilization review	2	2	2	**6**

OHA review: (Oral health integration) Exemplary project for peer sharing. Program builds on past work and uses SMART metrics. HIT ties are directly related to the other integration efforts with the goal of creating a closed-loop referral system. The prior year assessment and project context give detailed background about why CCO chose this project and anticipates questions about why CCO chose the benchmarks they did. Goals for the project move things forward while being realistic about how much CCO can complete during the measurement timeframe. This is a very successful program that was supported by a HRSA grant through the PCO. It has taken a lot of work and support from OHA, in addition to Advanced Health's and the community's commitment to get this off the ground. It would be great to share what they have been able to do and see if we can encourage spread.

(Utilization review) Project directly links UM to quality of care. Clear mechanisms in place to detect under and overutilization of services through the Tableau dashboard and gap lists (specifically for oral health utilization). Activities are all feasible as written and used SMART objectives.

OHA recommendations: (Oral health integration) None.

(Utilization review) Clearly identify number of members that are part of the intervention target group. Include more detail about the education provided to primary care providers on consistent messaging (referenced in the project narrative). This likely should have been incorporated as monitoring measure for activity one.

Project ID# 44: Community Collaborative – Initiation and Engagement in SUD Treatment

Component	Relevance score	Detail score	Feasibility score	Combined score
Access: Timely	3	2	3	**8**
Behavioral health integration	3	2	3	**8**

OHA review: (Access: Timely) The expansion of the behavioral health provider network co-located in primary care and specialty clinics creates additional timely care opportunities for members in need. Project/activities clearly describe a plan to improve member access to BH services within required timeframes and demonstrate oversight of provider network to monitor improvements. Activities selected directly relate to timely access and are likely to make progress for the gap identified in a reasonable timeframe.

(Behavioral health integration) Project looks to build SUD integrated infrastructure with focus on improving identification, referral to treatment and enhanced initiation and engagement as outcomes using claims data. Use of peers in bridging wait time and navigation barriers through completion of treatment.

OHA recommendations: (Access: Timely) In Activity 1.1, describe how pilot clinics will be identified and when the pilot program will begin. In Activity 2.1, describe who will develop the workflow (Advanced Health, primary care clinic, BH team, peer specialists all/none).

(Behavioral health integration) Pare down the narrative to focus information and help reader follow the steps taken and being planned. Include more data and include root causes for the barriers identified. Clarify where the SUD peers would be housed (in the primary care clinic?).

Project ID# 45: Improve Language Services Access

Component	Relevance score	Detail score	Feasibility score	Combined score
Access: Cultural considerations	3	2	2	**7**
Health equity: Cultural responsiveness	2	2	1	**5**

OHA review: (Access: Cultural considerations) The description and context for the project are clear, as are the general activities. Minor clarifying details are needed for the project activities. The overall project plan and activities seem generally feasible, but without more detail it is unclear if the activities are fully feasible.

(Health equity: Cultural responsiveness) Extensive background provided. The project does not address state and federal laws in the design of the effort. CCO focus on language access seems to be LEP populations (missing Deaf and Hard of Hearing). Some activities are appropriate but some lack SMART goals. Measurements and targets are not appropriate.

OHA recommendations: (Access: Cultural considerations) Ensure activities and monitoring measures (aside from 3.3) have targets and goals that are SMART: specific, measurable, attainable, relevant and time-based. Examples of detail and feasibility improvements:

- Activity 1.1: Include how much funding is available and how the CCO is identifying recipients. Without more detail, the activity may not be feasible in the target timeframe.
- Activity 2.1: Include the number of listening sessions that are planned, how CCO will be engaging and inviting the public, and how CCO intends to use the information gathered at each session.
- Activity 3.1: Be more specific about the approximate number of languages for which the service can provide video interpretation. Clarify how monitoring video interpretation will be different than the current monitoring process for the language service.

(Health equity: Cultural responsiveness) Include Deaf and Hard of Hearing populations to ensure full compliance with state and federal laws. Note developments on HB 3359 and interpreter access. Clarify how

the CCO plans to expand interpreter services. Describe barriers to the adoption of remote/video interpreter services. Use SMART goals.

Project ID# 46: Roadmap to Improved Behavioral Health Access and Integration				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Access: Quality and adequacy of services	3	3	3	**9**
Serious and persistent mental illness	3	3	2	**8**

OHA review: (Access: Quality and adequacy of services) Project clearly describes plan to improve access to behavioral health providers, uses data to identify gaps, identifies and addresses SPMI target population and fully addresses availability of licensed providers. Project and related activities are sufficiently detailed regarding prior year assessment and justification context. Continued project detail provided. Activities, targets, benchmarks and data sources are feasible as described and objectives are SMART.

(Serious and persistent mental illness) Specificity and measurability has improved, demonstrating implementation and improvement. Listening sessions demonstrate patient-centered systems development. Even with challenges from COVID and workforce shortages, creating drafts toward developing procedures for using the dashboards would be expected due to the importance of intervention for this population, especially with the increased number of providers engaging with the data.

OHA recommendations: (Access: Quality and adequacy of services) None.

(Serious and persistent mental illness) Set improvement targets prioritizing some providers over others and rationale for choosing one set over another (should be possible at this phase).

Project ID# 361: Patient-Centered Primary Care Home Advancement and Enrollment				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
PCPCH: Member enrollment	1	2	1	**4**
PCPCH: Tier advancement	2	2	1	**5**

OHA review: (PCPCH: Member enrollment) Project did not have a clear plan about how the CCO will increase member enrollment in PCPCHs. While this project included a lengthy narrative about activities in 2021 and the status of current PCPCHs in their network, there was little connection to the project plan for 2022. It's not clear how the CCO is working to achieve the enrollment targets.

(PCPCH: Tier advancement) The project plan is lacking details about how the activities and monitoring measures will support PCPCHs in advancing tier levels. Unclear how a provider portal for accessing data will help support a practice in advancing their PCPCH tier level. Activity 2 mentions TA to practices, but there is no monitoring measure to track TA.

OHA recommendations: (PCPCH: Member enrollment) Include more details as described above.

(PCPCH: Tier advancement) Include more details as described above. Add monitoring measure to track TA.

Project ID# NEW: Dual Eligible – Special Health Care Needs				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Special health care needs: Full benefit dual eligible	0	n/a	n/a	**0**

OHA review: Strong narrative project detail. It is noticeable that plan is aligning work to the CCO-LTSS MOU process. The project has identified in detail the population and need. However, project does not clearly meet SHCN requirements in addressing and tracking health care outcomes data. Project seeks to align a process but has not identified clear short- or long-term monitoring activities and health outcome metrics for the population. The project is feasible and work is required in contract, but CCO needs to get from vague goals to specific monitoring activities that address health improvement for the identified population. CCO has identified some important places in narrative that could be more developed into robust and measurable health outcome improvement. Good to see open lines of collaboration with affiliated MA plan.

OHA recommendations: Review TQS guidance for SHCN projects. Better alignment with component-specific requirements will help CCO achieve success. Identify specific monitoring activities that address health improvement and track health care outcomes data. Clarify what numbers mean in the benchmarks. Is CCO wanting to reduce hospital readmissions or unnecessary ED visits? In activity 3, CCO could ensure it tracks care plan development and sharing of care plans developed with all providers. In activity 2, CCO could monitor x% of providers receiving HEN and SNF.