2025 update: For 2025, coordinated care organizations (CCOs) will attest to meeting Transformation and Quality Strategy (TQS) requirements instead of submitting a full deliverable for Oregon Health Authority (OHA) approval. This guidance document describes the attestation requirements.

OHA recognizes that the projects included in the CCO's TQS are a showcase of current CCO work addressing TQS components that aim to make significant movement in health system transformation. Additionally, OHA recognizes that the TQS is not a comprehensive catalogue or full representation of the CCO's body of work addressing each component. CCOs should be continuing all other work that ensures the CCO is meeting all Oregon Administrative Rules (OARs), Code of Federal Regulations (CFR) and CCO contract requirements.

Contents

Purpose

This document outlines the OAR and CCO Contract requirements for the 2025 TQS attestation.

Per CCO contract, CCOs will continue to move health care transformation forward to meet the triple aim of better health, better care and lower costs. Where applicable, integrating the work of health care transformation with the federally required quality elements will allow CCOs to adopt synergistic activities. This synergy will help reduce duplicative activities, align CCO priorities and enhance innovation supported by targeted activities.

Timeline

Your CCO must submit its **2025 TQS attestation by May 15, 2025**, via the CCO Contract Deliverables Portal. (The submitter must have an OHA account to access the portal.)

Resources and contact information

All TQS guidance documents and resources for 2025 are posted to the CCO Contract Forms webpage and TQS TA webpage. Please send questions and communications to Transformation.Center@odhsoha.oregon.gov.

TQS components

Your CCO must address all nine TQS components listed here (see "Component-specific requirements" section below) with a project that includes monitoring activities, targets and benchmarks.

1	Behavioral Health Integration	6	PCPCH: Tier Advancement
2	Culturally and Linguistically Appropriate Services (CLAS) Standards	7	Serious and Persistent Mental Illness (SPMI)
3	Health Equity: Cultural Responsiveness	8	Special Health Care Needs (SHCN): Full Benefit Dual Eligible (FBDE) Population
4	Oral Health Integration	9	SHCN: Non-FBDE Medicaid Population
5	Patient-Centered Primary Care Home (PCPCH): Member Enrollment		

One project per component is required, but CCOs may have additional projects. CCOs could use one project to satisfy multiple components as long as it addresses each component's requirements.

Continuing projects: Your CCO is generally expected to carry over projects from the prior year unless they have met their expected goals or other discontinuation criteria (see below). CCOs must update continued projects each year with new activities. It is essential for CCOs to demonstrate progress year over year to meet the transformation goals set across TQS components and move the health system forward.

Questions to consider:

- Are you moving the work to meet member and community needs?
- Does the continued project demonstrate progress from the previous year?
- Do the project activities move your CCO toward transformation in the component areas the project addresses?

Discontinuing projects: It's important to recognize when a project won't be able to make progress toward its goals. Innovation may result in "quick wins" and early adoption, or "fail fast" and the need to change course.

Considerations for discontinuing a project include:

1. Project has failed to meet its expected outcomes and cannot be adapted to meet the outcomes.
2. CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work.
3. Fully matured project that has met its intended outcomes.
4. Project fails to meet TQS requirements, which ensure health transformation and quality for Medicaid members, for the chosen component(s) based on OHA feedback and/or written assessment.

In 2025, CCOs won't need to report on or close out discontinued projects from the prior year.

Required elements of all TQS projects

A. REALD & GI data

- ✓ **Use REALD (race, ethnicity, language and disability) and GI (gender identity) data to 1) identify disparities and 2) design activities to address those disparities.** The REALD & GI requirement applies to all member-level data used in the TQS. For more guidance, see the "REALD & SOGI requirements across components" section of this guidance document.

B. Population

- ✓ **Define the population for the intervention.** Consider focusing on one or more priority populations. These populations would include:
  - ✓ Members in priority populations as defined by Regional Health Equity Coalitions (OAR 950-020-0010): communities of color; Tribal communities including the Nine Federally Recognized Tribes of Oregon and other American Indians and Alaska Natives people; immigrants; refugees; migrant and seasonal farmworkers; low-income individuals and families; persons with disabilities; and individuals who identify as lesbian, gay, bisexual, transgender or queer, or who question their sexual or gender identity.
  - ✓ Members in life transitions, as defined in Oregon's 1115 Medicaid waiver; and
  - ✓ Communities experiencing health disparities (as identified in the CCO's community health assessment or REALD & GI data analysis).

C. Activities and monitoring for performance improvement

For each TQS project, CCOs must design activities to address the gaps identified for the chosen population. Decide how each activity will be monitored and the desired outcome (benchmark and target). If the CCO has identified disparities by REALD & GI categories, include activities, measures, targets and benchmarks to address and monitor those disparities. For continued projects, CCOs must update the activities, targets, benchmarks and dates accordingly.

- ✓ **Activities**: These are the tasks, actions and interventions your CCO will complete during the project to achieve the chosen targets and benchmarks. These could be transformational changes to the larger system, or more foundational activities internal to the CCO (process or quality improvement changes).

- Choose activities that directly relate to the TQS components selected and the gaps identified.
- Plan meaningful CCO actions throughout the calendar year to move the project forward.
- Include an adequate number of activities to move the project forward in a reasonable time. The number of activities will vary across projects due to complexity and type of project.
- Design activities that are specific, measurable, achievable, realistic and time-bound (SMART). Your CCO is encouraged to go further and use SMARTIE goals (SMART plus inclusive and equitable). See more information about adding inclusion and equity to SMART goals.

✓ **Monitoring measures**: Identify the data, indicator or process measures your CCO will use to assess improvement in the project population as a result of the planned activities. Each activity must have at least one monitoring measure. For process measures, the monitoring may be a task (for example, a contract will be issued, partners will be convened and recommendations made).

- If monitoring measures use member-level data, disaggregate results by granular REALD & GI categories to track progress in eliminating disparities.

✓ **Baseline or current state**: This is the initial data measurement (may be collected by the CCO during investigation of scope of the "problem") and starting point from which the CCO will calculate the project's impact. A baseline should contain quantitative data (for example, numbers, rates, percentages), unless it is a process measure (for example, a contract is not yet in place, stakeholder group has not been formed). If your CCO is continuing a project from a prior year's TQS, the current state data point will replace the baseline from the prior year.

✓ **Target/future state**: The target is the incremental step toward achieving the benchmark and should reflect what your CCO plans to accomplish or complete in the short term.

- If your targets are tracking member-level data, disaggregate results by granular REALD & GI categories for any disparities you're trying to eliminate.
- Define your target/future state using SMARTIE (specific, measurable, achievable, relevant, time-bound, inclusive, equitable) objectives. For reference, see this SMARTIE goals worksheet.
- Set a date by which the target will be met (generally within one year).

✓ **Benchmark/future state**: This is the standard or point of reference against which performance may be compared or assessed. CCOs may select national, state or industry best practice standards, or benchmark against their own performance if they have already met national, state or industry standards. Consider using statistical significance testing to set meaningful benchmarks.

- If your benchmarks are tracking member-level data, disaggregate results by granular REALD & GI categories for any disparities you're trying to eliminate.
- Define your benchmark consistent with SMARTIE (specific, measurable, achievable, relevant, time-bound, inclusive, equitable) objectives. For reference, see this SMARTIE goals worksheet.
- Set a date by which the benchmark will be met (could be multiple years).

REALD & SOGI requirements across components

Achieving health equity requires high-quality REALD (race, ethnicity, language and disability) and SOGI (sexual orientation and gender identity) data; without it there is no effective means for identifying where inequities exist. CCOs must be mindful that quality improvement may not benefit all populations equally. Careful measurement is vital to improving equity. Without REALD & SOGI data analysis, disparities and inequities within and across member groups in health and service delivery go unnoticed, even as CCOs seek to improve services.

Your CCO shall adopt processes that allow stratification of quality data by members' REALD & SOGI in every area of the organization as a tool for uncovering and responding to health care disparities and inequities. For more resources, see OHA's REALD & SOGI implementation page.

TQS projects that use CCO member-level data need to use REALD & GI (race, ethnicity, language, disability and gender identity) data for identifying disparities and designing activities to address those disparities. Note: While TQS requirements will be moving toward using full SOGI (sexual orientation and gender identity) data, CCOs don't yet have access to member-level sexual orientation data.

TQS projects that use member-level data must:

- ✓ Analyze all aspects of REALD & GI
- ✓ Identify any disparities
- ✓ Include project activities to address those disparities
- ✓ Include measurable policy or programmatic activities to address any inequities identified
- ✓ Disaggregate member-level targets and benchmarks by REALD & GI categories
- ✓ Have a plan for using sexual orientation data when it's available

TQS projects that use member-level data must:

1. **Analyze REALD & GI data to identify disparities**
   - ✓ Complete a full analysis at the most granular level possible.
   - ✓ Analyze every element of REALD & GI. (For example, a project that analyzes race, ethnicity and language but not disability or gender identity is not meeting this requirement. Consider doing intersectional analysis of REALD & SOGI data to better uncover disparities.)
   - ✓ Identify disparities or gaps across REALD & GI categories at the most granular level possible.
     - OHA expects CCOs to collect and analyze REALD & SOGI data at the most granular level possible (for example, Chinese, Korean, Japanese, etc. instead of "Asian").
     - CCOs may develop interventions for small populations, but use discretion in reporting numbers for such groups to ensure they protect confidentiality.
     - For reporting, especially those projects focusing on smaller populations, CCOs may need to roll up the data into intermediate or "parent" categories.
2. **Use REALD & GI data to address disparities**
   - ✓ If disparities were identified for the project population, include project activities and measures to address those disparities.
   - ✓ If inequities were identified for the project population, include measurable policy and programmatic activities to address the inequities.
   - ✓ Have a plan for using sexual orientation data to identify and address disparities once the data is available.

4. **Track member-level measures by disaggregated REALD & GI categories**
    - ✓ If the project includes activities to address disparities, include targets and benchmarks that are disaggregated by granular REALD & GI categories to monitor progress.

REALD & GI component-specific guidance

The REALD & GI requirement is only tied to any CCO member-level data that is involved in the project. For the following components, the REALD & GI requirement may or may not apply depending on the project:

- **PCPCH: member enrollment** – If your CCO uses individual criteria to assign members to a PCPCH, your TQS project for this component needs to use REALD & GI data (and have a plan for using sexual orientation data). If your CCO does not use individual criteria for assigning members to PCPCHs, the REALD & GI requirements won't apply to your TQS project for this component.
- **PCPCH: tier advancement** – If your CCO uses member-level data to prioritize or plan tier advancement supports for clinics, your TQS project for this component needs to use REALD & GI data (and have a plan for using sexual orientation data). If your CCO doesn't use member-level data to prioritize or plan tier advancement support for clinics, the REALD & GI requirements won't apply to your TQS project for this component.

Resources

- CMS Framework for Health Equity 2022–2032
- Medicaid Initiatives to Address Racial/Ethnic Health Disparities, FY 2022–2023
- Evaluating Medicaid's Use of Quality Measurement to Achieve Equity Goals
- Recommended Health Equity Measure Accountability Framework for ACO Contracts

Component-specific requirements

TQS components: Below is a description of each TQS component. CCOs must have a TQS project that addresses each of the components. Applicable OARs, CFRs and contract references are listed to provide further details on component meanings. Project examples listed are to provide CCOs with ideas of projects to develop and implement; examples are not an exclusive or exhaustive list.

1. Behavioral Health Integration

This component refers to your CCO's development and implementation of an equitable, integrated, person-centered behavioral health system that seamlessly and holistically integrates physical, behavioral and oral health. This system should be one that members can count on, regardless of where they live, to meet their needs. The system should support all integration models from communication to coordination to co-management to co-location to the fully integrated patient-centered primary care home and behavioral health home. If applicable to your CCO's project, OHA encourages including technical assistance for your CCO's delivery system focused on integrated behavioral health payment models, including the billing code and modifiers for integrated services.

TQS projects for this component must:

- Demonstrate clear understanding of definition and models of integration.
- Integrate behavioral health and physical health and/or behavioral health and oral health, including but not limited to integrated setting, care coordination, or transitions of care.
- Cover the continuum of care — prevention, treatment, maintenance and recovery — or cover a part of the continuum of care while clearly demonstrating the project advances integrated care (that is, the project connects individuals to other parts of the continuum of care if indicated).
- Demonstrate how the integration model makes the behavioral health system more equitable (that is, decreases health disparities and improves health outcomes).
- Use the electronic health record/health information exchange system to support the delivery of integrated care.
- Implement a care team structure that includes all disciplines involved in the member's behavioral health and primary care.
- Include strong collaboration and partnership with other regional health providers such as school-based health centers, substance use disorder providers, community mental health programs and primary care providers, and other community partners such as law enforcement.

Project examples:

- Allow members to receive primary care services in behavioral health settings. For example, any of the following activities in a behavioral health setting would be considered integration:
    - Tobacco cessation for people with severe mental illness
    - Diabetes self-management and monitoring for diabetes
    - Screening for metabolic syndrome for all clients on an anti-psychotic medication
    - Offering all preventive screenings such as colonoscopies or mammograms for individuals with severe mental illness

    - Hiring a primary care provider in a community mental health program
- Allow members to receive behavioral health services in a primary care setting (for example, providing depression screening in a primary care setting).
- Increase the availability of integrated behavioral health services, including increasing the capacity and number of integrated behavioral and physical health providers and clinics.
- Pay for behavioral health services using payment models that promote integration, such as paying for behavioral health and physical health visits that occur on the same day in the same clinic, eliminating double co-pays and contracting with integrated clinics for all services in one contract.
- Provide technical assistance for using billing codes and/or modifiers for integrated services.
- Develop and implement plans, through collaboration between the behavioral health community and physical health or oral health, to expand the range of behavioral health services that engage individuals in the community with the services and supports they need, when they need them, where they need them, and at the right intensity.
- Increase utilization of comprehensive screenings of mental health, substance use disorder and physical health, using evidence-based screening tools, in physical and behavioral health care settings.
- Provide training and support to increase member access to medication-assisted treatment.
- Develop and implement processes to improve and standardize communication between physical and behavioral health providers.
- Engage members in assessing experience with integrated behavioral health. Develop and implement processes and projects to use the feedback to improve care across members.
- Improve coordination of care between the behavioral health system and primary care provider. Projects should focus on the most vulnerable populations. This is especially crucial to support effective member transition between levels of care, different systems and providers to improve care outcomes, reduce over-utilization, reduce additional trauma to the member due to system issues and realize cost-effective savings in the long term.

Considerations in developing projects:

- How is your CCO providing members access to a full range of behavioral health treatment and recovery options in the member's preferred setting of care (such as primary care clinics and behavioral health clinics)?
- How is your CCO assessing timeliness of access to services, and how will your CCO address gaps and improve access?
- How is your CCO improving collaboration with community behavioral health providers to expand the range of behavioral health services in the community?
- How is your CCO increasing member access to medication-assisted treatment when medically appropriate?
- How is your CCO assessing and supporting seamless integration of the behavioral health benefit, and how will your CCO address any gaps?
- How are trauma-informed services integrated into your system of care? What opportunities are there for improvement?

- What percentage of members are screened for mental health, substance use disorder and physical health care using evidence-based screening tools? What opportunities are there for improvement?
- How is your CCO contracting and paying for behavioral health services that promote integration? What opportunities are there for improvement?

2. CLAS Standards

This component refers to your CCO's work in implementing activities to support the National Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS Standards Blueprint is a central guidance document for CCOs and provider networks on how to implement and sustain CLAS standards to address inequities at every point where the member has contact with the health care system. The CCO contract requires CCOs to implement and sustain CLAS standards as a part of its foundation and operations.

Projects for this component will help move the CCO's work in meeting the CLAS standards in health care. The CLAS Standards Blueprint defines "culturally and linguistically appropriate services" in CLAS standard 1 as the provision of effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. Standard 1 is the principal standard because it is the ultimate aim in adopting the remaining standards. Standards 2 through 15 represent the practices and policies intended to be the fundamental building blocks of culturally and linguistically appropriate services that are necessary to achieve standard 1. For this reason, CCOs will choose from standards 2 through 15 for focusing their TQS project(s). For OHA, the sustained incorporation of CLAS standards in every aspect of the CCO and provider network is the primary long-term goal.

TQS projects for this component must:

- Include activities and monitoring to address the specific CLAS standard selected (see the CLAS Blueprint).
- Focus on transformation — that is, fostering innovative, transdisciplinary, culturally and linguistically responsive and impactful projects and programs to improve the health of OHA priority populations.
- Include activities to move toward a health care delivery system that improves access, experience and outcomes for people living in Oregon who communicate in languages other than English. This includes supporting people with disabilities.
- Measure quality improvement over time. Quality improvement is the framework used to systematically improve health care and services.
- Advance the provision of effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, multiple languages, health literacy and other communication needs for people with disabilities.

The following are relevant references for this component:

- The 15 National CLAS Standards are intended to advance health equity, improve quality and help eliminate health care disparities.

- For a robust and comprehensive guide on how to implement CLAS standards, see the National CLAS Standards Implementation Checklist.

Project examples:

- Develop a monitoring system for language assistance services to analyze existing services to improve upon how they can become more accessible, effective and efficient.
- Develop required scripts for CCO staff and all network providers for consistently informing people of the availability of language assistance and asking whether they will need any of the available services (short term).
- Develop an evaluation system to assess the quality of translations for member materials. This should include testing materials with target audiences.
- Integrate CLAS into continuous quality improvement processes (for example, organizational assessments, CLAS-oriented surveys for consumers, focus groups with staff and consumers to identify barriers to CLAS implementation, CLAS-related questions in staff orientation materials and yearly reviews).

Considerations in developing projects:

- What does current CCO data tell us about the language needs of members?
- What does current state and local data tell us about potential CCO members?
- How do local community listening sessions and community advisory councils inform or shape which CLAS standards your CCO is focusing on?
- How does current demographic data about CCO employees and the current demographic data about CCO membership help evaluate and inform which CLAS standards are chosen?
- What were the highest priorities identified by the CCO, and which National CLAS Standard(s) can help the organization address those needs?
- What broader contexts (for example, regulatory environment, mandates, standards of practice) might influence the CCO goals and objectives, and which National CLAS Standards should the CCO adopt first? Are there opportunities to align those goals and objectives with these broader contexts? Can the community be involved?
- When evaluating projects, to what extent has the implementation of the National CLAS Standards led or contributed to:
    - The use of data on race, ethnicity, sex, gender identity, disability status, and language to monitor and improve health service delivery?
    - Improved two-way communication between providers and members?
    - Increased knowledge of culturally and linguistically appropriate care and buy-in from staff?

3. Health Equity: Cultural Responsiveness

This component refers to your CCO's application of an equity-centered care management system to identify and address systemic inequities in services, policies, practices and procedures with a focus on eliminating racial, ethnic and linguistic health disparities from a quality and transformation perspective.

CCOs are encouraged to center their equity work in OHA's health equity definition:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- *The equitable distribution or redistribution of resources and power; and*
- *Recognizing, reconciling, and rectifying historical and contemporary injustices*.

OHA expects your CCO to move health equity forward through transformation and quality projects.

- **Quality improvement** is the framework used to systematically improve health care and services.
- **Transformation** means focusing on innovative, transdisciplinary, culturally and linguistically responsive and impactful projects and programs to improve the health of OHA priority populations.

CCOs will ensure an adequate health equity infrastructure is part of their foundation and operations through additional requirements in the CCO contract (see Exhibit K for health equity infrastructure details). CCOs' work of building their equity infrastructure using their health equity plans allows them to have **equity foundations**. Those foundations are necessary to identify inequities and disparities and take responsibility, create systems, and implement policies and processes for addressing them using an equity-centered approach, because they have explicitly prioritized equity as a key component of their organization mission and goals. If your CCOs is using items from your health equity plan in your TQS project, your TQS project must be transformative, inclusive and equitable.

Culturally responsive services are those that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse consumer/client populations and communities whose members identify as having particular cultural or linguistic affiliations based on their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home. **Cultural responsiveness** describes the capacity to respond to the issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual.[1]

Your CCO shall ensure that members receive culturally and linguistically, effective, understandable and respectful care from all CCO staff and the provider network. The CCO shall ensure that health and health care services (including physical health, behavioral health, substance use disorder and oral health services) are provided in a manner compatible with members' cultural health beliefs, practices, preferred language and communication needs.

TQS projects are expected to align — but move beyond — contractual obligations to focus on quality improvement and transformation.

TQS projects for this component must:

- Address quality and/or transformation (see definitions above).
- Identify clear goals that are inclusive and equitable.

[1] Department of Health (2009). Cultural Responsiveness Framework: Guidelines for Victorian Health Services. Rural and Regional Health and Aged Care Services, Victorian Government, Melbourne. Victoria

- Demonstrate knowledge and consideration of state and federal laws regarding communication and accessibility in the project design and implementation.
- Improve and/or transform the services, assistance and support members receive in accessing and navigating the health care delivery system, community and social support services and statewide resources.

The following are relevant references that need to be considered when designing projects for this component:

- In accordance with OAR 410-141-3590(2), OAR 410-141-3705(15) and OAR 410-141-3580(6-7), CCOs shall ensure members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources. This includes, but is not limited to, the use of certified or qualified health care interpreters, advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and to participate in processes affecting the member's care and services.
- CCOs shall have written policies and procedures that ensure compliance with the Americans with Disabilities Act as amended in 2008 and Section 1557 of the Affordable Care Act (45 CFR Part 92) in providing access to covered services for all members and shall arrange for services to be provided by non-participating referral providers when necessary (OAR 410-141-3515(13)).
- CCOs shall ensure members and potential members are aware of their rights to free, accurate and timely spoken and sign language interpretation services in any language by a certified or qualified health care interpreter as described in OAR 410-141-3580, OAR 410-141-3585 and 45 CFR 92.201.
- Your CCO shall develop and provide written informational materials and educational programs in the member's preferred language and at a sixth grade reading level or below as described in OAR 410-141-3580 and OAR 410-141-3585. Your CCO shall furnish materials and programs in a manner and format that may be easily understood and tailored to the backgrounds and special needs of the member, or potential member, and that comply with the federal requirements in 42 CFR 438.10.
- In compliance with the Americans with Disabilities Act, any written material that your CCO generates and provides under the CCO contract to clients or members, including Medicaid-eligible individuals, shall, at the request of such clients or members, be reproduced in alternate formats, including braille, large print, audiotape, oral presentation, and electronic format (CCO Contract Ex D, Sec 2b).

Many opportunities exist for CCOs to demonstrate cultural responsiveness within processes established by the CCO and subcontractors using quality improvement and transformation activities.

Project examples:

- Develop improvement strategies for monitoring systems that track the use of interpreter services (in person and video/phone) to ensure members are aware of their rights to interpretive services.
- Develop improvement strategies to ensure and improve quality interpretive services available to members.

- Develop innovative processes and service improvement strategies to ensure subcontractors such as non-emergent medical transportation can field calls in other languages and accommodate callers with disabilities.
- Develop processes to measure the effectiveness of CCO training efforts using learner outcomes (pre/post test scores, course completion rates) and process measures (hours of training completed, trainer satisfaction and participant engagement). It's important to use a mix of both types of metrics to get a well-rounded view of a training's effectiveness.
- Develop systems and processes to ensure behavioral and oral health services are culturally and linguistically appropriate.

Considerations in developing projects:

- Does the project clearly address quality improvement or transformation for advancing health equity?
- Does the project align with the OHA health equity definition?
- Does the project clearly explain how the activities support the OHA health equity definition?
- Has your CCO used an equity framework or a health equity impact assessment to inform this project?

4. Oral Health Integration

This component refers to your CCO's development and implementation of an equitable health care delivery model that seamlessly and holistically integrates physical, behavioral and oral health. The goal of an oral health integration project is to enhance access to oral health services by integrating oral health into primary and behavioral health care, as well as promoting the role of the dental office as a part of whole-person care.

TQS projects for this component must:

- Allow members to receive targeted non-oral health care, such as diabetes, hypertension and tobacco screenings, and referrals from a dental provider **OR** oral health care and referrals in their primary care or behavioral health provider's office; **and**
- Allow members to access oral health care outside of the traditional dental office; **and**
- Enable dental providers to share member health information with primary care and behavioral health professionals through health information technology.

The following are relevant references for this component:

- Oral Health Integration Resources (Qualis Health)
- Organized, Evidence-Based Care: Oral Health Integration Implementation Guide (Safety Net Medical Home Initiative)
- Integration of Oral health and Primary Care Practice (US Health and Human Services)
- Gambhir RS. Primary care in dentistry: an untapped potential. J Family Med Prim Care. 2015 Jan-Mar; 4(1): 13–18.
- Integrating Oral Health Care and Primary Care Learning Collaborative: A State and Local Partnership (National Maternal and Child Oral Health Resource Center, Georgetown University)

Project examples:

- Care coordination targeting tobacco users, pregnant members and members with diabetes and hypertension for oral health interventions that improve overall health outcomes.
- Electronic oral health records to support work and connect to other health records within the CCO systems.
- Expanded delivery modalities, such as co-location, tele-dentistry, and cross-training of medical professionals.

Patient-Centered Primary Care Home (PCPCH)

Your CCO shall support the continued adoption and advancement of the Oregon Patient-Centered Primary Care Home (PCPCH) model within clinics. Your CCO shall develop and use PCPCH and other patient-centered primary care approaches to achieve the goals of health system transformation (CCO Contract Ex. B, Pt. 4, Sec. 6, Para. a).

PCPCH means a health care team or clinic as defined in ORS 414.655 that meets the standards pursuant to OAR 409-055-0040 and has been recognized through the process pursuant to OAR 409-055-0040.

While the components below use the 2020 PCPCH Recognition Standards, CCOs are encouraged to consider strategies that could be applied to the 2025 PCPCH standards.

5. PCPCH: Member Enrollment

CCOs shall ensure that a significant percentage of members are enrolled in PCPCHs recognized as Tier 1 or higher according to Oregon's PCPCH recognition standards.

If your CCO earned a weighted PCPCH enrollment score of at least 85% in 2023 (as reported to and validated by OHA for 2023), your CCO is not required to have a TQS project for PCPCH: Member Enrollment in 2025. In this case, in the 2025 TQS attestation form you may include "Not required: Met threshold" instead of listing a project name for this component.

The PCPCH weighted score formula = (# of members in Tier 1 clinics *1) + (# of members in Tier 2 clinics*2) + (number of members in Tier 3 clinics*3) + (# members in Tier 4 clinics*4) + (# members in 5 STAR clinics*5) / (total # of CCO members*5).

The REALD & GI requirement in TQS applies to any CCO member-level data used in projects. If your CCO uses individual criteria to assign members to a PCPCH, your TQS project for this component needs to use REALD & GI (and have a plan for using sexual orientation data).

TQS projects for this component must:

- Have a comprehensive plan for increasing member assignment to PCPCHs. The plan should include activities for increasing the number of enrollees served by recognized PCPCHs, including targets and benchmarks.

The following are relevant references for this component:

- Oregon Patient-Centered Primary Care Home Program website
- Your CCO shall encourage the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as PCPCHs to ensure the continued critical role of those providers in meeting the health of underserved populations (CCO Contract Ex. B, Pt. 4, Sec. 6, Para. f).

Project examples:

- Strategy to increase members assigned to recognized PCPCHs.
- Strategy to increase the number of PCPCHs in your CCO's network that includes identifying and contracting with PCPCHs in your service area that are not in your network.
- Strategy to increase the number of PCPCHs in your network by providing technical assistance to non-PCPCH primary care practices in your network to apply for PCPCH recognition. Technical assistance could include individual technical assistance, learning collaboratives (in-person or virtual) and/or educational webinars.

6. PCPCH: Tier Advancement

TQS projects for this component must have a comprehensive plan to support PCPCH practices in upward tier recognition. The plan must include targets and benchmarks that support PCPCHs to advance from Tier 1 toward Tier 5 in Oregon's PCPCH recognition standards.

The REALD & GI requirement in TQS applies to any CCO member-level data used in projects. If your CCO uses member-level data to prioritize or plan tier advancement supports for clinics, your TQS project for this component needs to use REALD & GI (and have a plan for using sexual orientation data).

Project examples:

- Learning collaboratives (in-person or virtual) or individual technical assistance for Tier 4 PCPCHs applying for Tier 5 PCPCH recognition.
- Learning collaboratives (in-person or virtual) or individual technical assistance to PCPCHs applying for a higher PCPCH tier level.
- Target one or two practices and work with them to apply for Tier 5 PCPCH recognition. Practices that are reluctant to apply for Tier 5 may be more likely to apply if they have coaching and support.
- Value-based payment arrangements with PCPCHs that encourage and support higher tier level attainment.

7. Serious and Persistent Mental Illness (SPMI)

In this component, your CCO shall demonstrate improvement in an area of poor performance in care coordination for members with SPMI, even if this population overlaps with other designations such as civil commitment, aid and assist, and the psychiatric security review board. While it's important to identify the parameters and requirements in rule and contract, the goal of SPMI TQS projects should be to bolster the care coordination between payer, provider and patient to improve patient outcomes.

TQS projects for this component must:

- Plan to improve an area of poor performance in care coordination for members with SPMI, which reflects a thorough understanding of the effects of SPMI on individual functioning, access to care, and utilization of services;
- Support self-determination and be person centered;
- Demonstrate clear commitment to providing services in the most integrated setting;
- Develop a method of collecting data indicating the number of members identified and interventions used;
- Be informed by social determinants of health; and
- Focus on improving patient outcomes.

The following are relevant references for this component:

- Your CCO shall have a process for coordinating care for members determined through assessment to need a course of treatment or regular care monitoring (OAR 410-141-3860 through OAR 410-141-3870). The procedure shall include drafting a treatment/care plan and formally designating a person or entity as primarily responsible for coordinating the services (42 CFR 438.208).
- Your CCO shall provide care coordination or case management services to members with SPMI receiving home and community-based services under the State's 1915(i) State Plan Amendment (CCO Contract Ex. B, Pt. 4, Sec. 9, Para. a).
- Your CCO shall ensure access to supported employment services for all adult members with SPMI seeking these services, in accordance with OARs 309-019-0275, 309-019-0280, 309-019-0282, 309-019-0285, 309-019-0290 and 309-019-0295. "Supported employment services" means the same as "individual placement and support (IPS) supported employment services" as defined in OAR 309-019-0225 (CCO Contract Ex. M, Pt. 3, Sec. h).
- Your CCO shall have policies and procedures for assessing and producing a treatment plan (individual service and support plan) for each member identified as having a special health care need and determined to need a course of treatment or regular care monitoring (CCO Contract Ex. B, Pt. 4, Sec. 9, Para. a, Sub Para. (3) and Ex. B, Pt. 4, Sec. 2, Para. a, Sub Para. (6)).
- Your CCO shall have policies and procedures for producing an individual care plan for individuals with SPMI who have two or more readmissions to either an emergency department or acute care psychiatric facility within a 6-month period.

Special Health Care Needs (SHCN)

In the SHCN components, your CCO shall **identify a population** within your special health care needs population and focus on evidence-based strategies or actions to improve health outcomes of the selected population's health condition(s). You can use a number of data sources to identify areas where poor outcomes, lack of member engagement, lack of regular health care appointments, lack of discharge education, or other multiple risk factors contribute to poor health outcomes for your targeted population.

Quality improvement should focus on evidence-based approaches that create structured **strategies to improve your target population's health**. Your CCO can use any number of innovative approaches, such as

increasing focus within care coordination, improving data sharing with partners engaged in member care, increasing member engagement or outreach with traditional health workers, building member self-management skills for their disease, medication management or monitoring, or engaging specific chronic care strategies in care plan development and monitoring.

Projects must **measure health variables that are relevant to showing improvements**. Projects that do not focus on identifying and measuring short- and long-term monitoring activities related to member health improvements will not meet this component's requirement. See the examples table below for types of measurable activities needed for a successful SHCN quality improvement project.

The SHCN components refer to your CCO's analysis of the quality, impact and appropriateness of care provided to members with special health care needs used to:

- Ensure that each member with SHCN has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services;
- Monitor the mechanism that allows members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs;
- Produce a treatment or care plan for members with SHCN that's determined through assessment to need a course of treatment or regular care monitoring;
- Coordinate all services and supports to which members are entitled, regardless of who provides the service, and collaborate with those entities to reduce duplication and identify gaps as outlined in OAR 410-141-3860. This includes appropriate discharge planning for short-term and long-term hospital and institutional stays (42 CFR 438.208(c)) to focus on reducing unnecessary readmissions and improving outcomes; and
- Track health variables that can demonstrate the effectiveness of your quality improvement project over time. Select meaningful variables that are linked to documenting health improvements for the selected population based on the unique needs and issues identified.

SHCN population definition (applies to both SHCN components):

As defined in OAR 410-120-0000, "Special Health Care Needs (SHCN)" means individuals of any age who experience or exhibit signs of developing:

a) Physical, functional, intellectual or developmental disabilities; or
b) Long-standing or chronic medical condition(s); or
c) Complex behavioral health conditions, including substance use disorders or serious and persistent mental illness; or
d) Live with other health or social conditions placing them at risk, that without intervention will likely cause negative impact to an individual's health or wellbeing.

Members receiving Medicaid-funded long-term care or long-term services and supports should be assessed and considered as a population that often has risks and health conditions that place them into SHCN populations.

Consider aligning your project with CCO metrics goals, such as increasing behavioral health screenings for members in long-term care settings or reducing hospital readmissions for members with SPMI or chronic

conditions. Your CCO could also look for when a SHCN population has outliers for certain CCO metrics (for example, interventions to improve chronic disease management, such as to reduce avoidable emergency room use for children with asthma). A key to selecting your project and health improvement targets is to understand the data for your members with special health care needs.

Every CCO is required to have two SHCN projects, focusing on the following populations:

1. **Full benefit dual eligible (FBDE) population**
2. **Non-FBDE Medicaid population**

The following are relevant references for SHCN TQS components:

- Mechanisms to assess the quality and appropriateness of care provided to enrollees with special health care needs (42 CFR 438.330(b)(4)).
- Coordination and continuity of care for CCO members with special health care needs using a report of aggregate data indicating the number of members identified and methods (42 CFR 438.208(c)).
- CCO contractual obligations for SHCN members (CCO Contract Ex. B, Pt. 4, Sec. 2, Para. g).
- Your CCO shall have policies and mechanisms for producing an integrated treatment or care plan (individual service and support plan), or transition of care plan, for each member identified as having a special health care need (CCO Contract Ex. B, Pt. 4, Sec. 2, Para. a, Sub Para. (3)).
- CCO-LTSS memorandum of understanding guidance to address elements related to CCO populations with complex care needs on collaborative care planning, care transitions and other elements.

Examples of short- and long-term health monitoring measures		
Note: Track all member-level measure data by REALD & GI categories		
Health topic	**Short-term health monitoring measures**	**Long-term heath outcome measures**
Diabetes	A1C testing/monitoring; diabetic medication refills; participation in diabetes self-management programs; regular primary care visits	Hemoglobin A1C control; avoidable emergency department visits
Mental illness	Discharge planning documents are being shared with all providers; referral and follow-up to appointments to manage chronic conditions; medication refills; regular behavioral health provider visits or documented peer services	Emergency department visits among members with mental illness; hospitalization rate among members with SPMI
Asthma	Primary care visits; medication refills and management; home visits for environmental trigger remediation	Hospital admissions; readmissions, avoidable ED visits
Dementia	Depression screening by primary care providers; health information exchange workflow for dementia care coordination and planning; integrated care plans; medication reconciliation	Unnecessary emergency department admission for members with dementia
Falls	Medication reconciliation and review; medication therapy management program participation; home visits for safety review/homes receiving safety modifications (railings, ramps); completion of fall prevention programs	Fall rate, hospitalizations for falls

8. SHCN: Full benefit dual eligible (FBDE) population

Note: See overall SHCN guidance above, which applies to both SHCN components.

TQS SHCN projects must clearly identify the project population and align the rationale, improvement objectives and monitoring activities to demonstrate how the CCO expects members with special health care needs (see SHCN population definition above) will benefit and see improvement from the project. **TQS projects for the SHCN components must document improvement in health status.** Projects that track health care services utilization or social determinants of health without clearly linking to health care improvements and outcomes for the project population do not meet the requirements for SHCN projects. This project must be focused on the CCO's full benefit dual eligible members with special health care needs for an issue(s) identified by the CCO and aligned Medicare Advantage (MA) plan(s). While a CCO can identify a project population larger than those in the aligned MA plan, the project must demonstrate clear collaboration with the aligned MA plan in ways that are within expectations for care coordination within CCO contractual affiliation expectations.

CMS strongly supports increased integrated care for FBDE members in CCOs and their affiliated/contracted MA plan or MA dual special needs plan (DSNP). DSNPs have been required since contract year 2020 to partner with their affiliated CCOs to implement a shared quality improvement project for a specific FBDE population with special health care needs. This provides an opportunity to address cross-system collaborative quality improvement to impact FBDE members with special health care needs who may currently not have access to integrated, coordinated or seamless processes with the MA/DSNP and other partners to meet CCO 2.0 goals. All CCOs are required to focus a TQS project on dual-eligible members with special health care needs.

TQS projects for this component must:

- **Identify a population within your FBDE members with SHCN**, as defined above, for which you are seeking to improve health outcomes.
- **Use evidence-based or innovative strategies** to ensure your identified population has access to integrated and coordinated care (appropriate care, care coordination, treatment plan, care transition processes and appropriate follow-up).
    - Considerations: Is there evidence that this type of intervention will achieve your targeted health improvement outcome? What innovations are driving your project? (For example, sending a brochure about diabetes would not be an innovative approach.)
- **Primarily focus on quality improvements related to improving health outcomes** for your identified SHCN population. These activities should have a clearly demonstrated ability to achieve the targeted health improvement(s) for the defined SCHN population. Select appropriate health variables to show targeted short- and long-range health improvements.
- **Identify and monitor health outcomes for your identified SHCN population. Include both short-term and long-term health monitoring.** See table of examples above. If the project only addresses underlying social factors, member surveys or access to services and not health outcomes, it will not meet this TQS component requirement. Ensure all monitoring activities have clearly defined and measurable objectives that can demonstrate progress toward targeted health improvements.

    - Use process measures to monitor your team's work to ensure targets are achieved — such as tracking referrals, appointments attended, traditional health worker home visits, medication refills, completion of screenings or annual medical testing — which ultimately help ensure health improvements will be achieved.
    - Use health outcome measures, such as reductions in unnecessary emergency department visits, hospitalizations or readmissions, or improvements in core health variables in people with chronic conditions or disabilities. Health outcome measures are the core of a successful project design.
- **Collaborate with your affiliated MA plan** in the project design, data sharing, monitoring and/or implementation and outcome measurements.

Questions to consider in developing projects:

- Does the project clearly connect the identified SHCN population and the project's rationale by using evidence-based documented information that supports specific health outcome improvements targeted by the project? (Why will this project improve member health?)
- Is the project likely to achieve health improvements through the chosen monitoring activities and metrics tracking? (That is, what do we know about the current state, what do we want to be the future state, and how will we get there?)
- What short- and long-term health data/metrics are you tracking to demonstrate health improvement for your project's population?
- How might working with any of your affiliated MA plans, including DSNPs, on a project around FBDE also address required CCO contract elements relating to care coordination, care transitions and care planning for your FBDE populations?
- What short-term and long-term measurable monitoring activities might be incorporated? Are monitoring activities easy to measure and show improvement? TQS projects should identify the key variables that will document (1) the improvement project is being implemented as designed and (2) those variables that show health improvement. Some examples of monitoring activities:
    - Short term: Are you tracking the following: referrals; follow-up on scheduled appointments after a transition; that discharge planning documents are being shared with all providers; utilization of preventive or wellness services; attendance at provider appointments to manage chronic conditions; medication review to identify any high-risk medications or ensuring prescriptions are being filled regularly?
    - Long term: Are you tracking metrics like the following: reducing readmissions or avoidable emergency department utilization; disparity measure for emergency department utilization among members with mental illness; improvements in PQI 05: COPD or asthma in older adults admission rate; PQI 08: congestive heart failure admission rate; PQI 15: asthma in younger adults admission rate; specific health care measures like reducing A1Cs, reduction in falls percentage in population, etc.? What Medicare metrics could we also be monitoring?
- What data might already be collected for required tracking and CCO Contract and Oregon Administrative Rule requirements around SHCN populations and subpopulations, and what links could be built into the project?

- How does the project align with specific health information exchange, behavioral health, DHS partner collaboration, or other core projects already in place?
- How might tracking referrals to and from LTSS be incorporated as a monitoring tool?
- Is your CCO using event notifications (from hospitals and skilled nursing facilities) and health information exchange to develop care guidelines, push out care notifications and build collaborative care plans with providers (how can this improve goals, outcomes and tracking)?
- How do you use data to ensure members are receiving screenings and preventive care, including behavioral health screenings, in your monitoring?
- How do you monitor care or service authorization data to track who may be underutilizing prevention and care management to improve outcomes?
- How might using utilization review or care management processes, including monitoring following care protocols and policies, provide valuable data?
- How are you using the data collected that's required by contract for follow-up to hospitalization, or following those members with multiple hospitalizations?
- How are you taking a deeper dive on social determinants of health that might be impacting unique populations like those with disabilities, issues in congregate care settings including populations in LTSS programs, or recently discharged to home after a skilled nursing facility stay?
- How are you taking a deeper dive on disparities in underserved populations (for example, seniors for whom English is not their primary language who access all sorts of services at much lower rates and have higher burden of chronic disease in Oregon)?
- How are you working with your affiliated MA or DSNP plans to align complex care processes for FBDE populations and identifying high priority goals for both partners to improve member health outcomes? For shared projects we encourage you to consider using both MA/DSNP metrics with your CCO metrics as outcome measures.

9. SHCN: Non-FBDE Medicaid population

Note: See overall SHCN guidance above, which applies to both SHCN components.

TQS SHCN projects should clearly identify the project population and align the rationale, improvement objectives and monitoring activities to demonstrate how the CCO expects members with special health care needs (see SHCN population definition above) will benefit and see health improvement from the project. Review the SHCN definition to ensure your project will meet requirements for a SCHN project. **TQS projects for the SHCN components must document improvement in health status.** Projects that track health care services utilization or social determinants of health without clearly linking to health care improvements and outcomes for a target population do not meet the requirements for SHCN projects.

TQS projects for this component must:

- **Identify a population within your non-FBDE Medicaid members with SHCN**, as defined above, for which you are seeking to improve health outcomes.

- **Use evidence-based or innovative strategies** to ensure your identified population has access to integrated and coordinated care (appropriate care, care coordination, treatment/care plan, care transition processes and appropriate follow-up).
    - Considerations: Is there evidence that this type of intervention will achieve your targeted health improvement outcome? What innovations are driving your project? (For example, sending a brochure about diabetes would not be an innovative approach.)
- **Primarily focus on quality improvements related to improving health outcomes** for your identified SHCN population. These activities should have a clearly demonstrated ability to achieve the targeted health improvement(s) for the defined SCHN population. Select appropriate health variables to show targeted short- and long-range health improvements.
- **Identify and monitor health outcomes for your identified SHCN population. Include both short-term and long-term health monitoring.** See table of examples above. If the project only addresses underlying social factors, member surveys or access to services and not health outcomes, it will not meet this TQS component requirement. Ensure all monitoring activities have clearly defined and measurable objectives that can demonstrate progress toward targeted health improvements.
    - Use process measures to monitor your team's work to ensure targets are achieved — such as tracking referrals, appointments attended, traditional health worker home visits, medication refills, completion of screenings or annual medical testing — which ultimately help ensure health improvements will be achieved.
    - Use health outcome measures, such as reductions in unnecessary emergency department visits, hospitalizations or readmissions, or improvements in core health variables in people with chronic conditions or disabilities. Health outcome measures are the core of a successful project design.

Questions to consider in developing projects:

- Does the project clearly connect the identified SHCN population and the project's rationale by using evidence-based documented information that supports specific health outcome improvements targeted by the project? (Why will this project improve member health?)
- Is the project likely to achieve health improvements through the chosen monitoring activities and metrics? (That is, what do we know about the current state, what do we want to be the future state, and how will we get there?)
- What short- and long-term health data/metrics are you tracking to demonstrate health improvement for your project's population?
- What short-term and long-term measurable monitoring activities might be incorporated? Are monitoring activities easy to measure and show improvement? TQS projects should identify the key variables that will document (1) the improvement project is being implemented as designed and (2) those variables that show health improvement. Some examples of monitoring activities:
    - Short term: Are you tracking the following: referrals; follow-up on scheduled appointments after a transition; that discharge planning documents are being shared with all providers; utilization of preventive or wellness services; attendance at provider appointments to manage chronic conditions; medication review to identify any high-risk medications or ensuring prescriptions are being filled regularly?

    - Long term: Are you tracking metrics like the following: reducing readmissions or avoidable emergency department utilization; disparity measure for emergency department utilization among members with mental illness; improvements in PQI 05: COPD or asthma in older adults admission rate; PQI 08: congestive heart failure admission rate; PQI 15: asthma in younger adults admission rate; specific health care measures like reducing A1Cs, reduction in falls percentage in population, etc.? What Medicare metrics could you also be monitoring?
- What data might already be collected for required tracking in CCO Contract and OARs around SHCN populations and subpopulations, and what links could be built into the project?
- How does the project align with specific health information exchange, behavioral health, DHS partner collaboration, or other core projects already in place?
- How might tracking referrals to/from prevention programs be incorporated as a monitoring tool?
- Is your CCO using event notifications (from hospitals and skilled nursing facilities) and health information exchange to develop care guidelines, push out care notifications and build collaborative care plans with providers (how can this improve goals, outcomes and tracking)?
- How do you use data to ensure members are receiving screenings and preventive care, including behavioral health screenings, in your monitoring?
- How do you monitor care or service authorization data to track who may be underutilizing prevention and care management to improve outcomes?
- How might using utilization review or care management processes, including monitoring following care protocols and policies, provide valuable data?
- How are you using the data collected that's required by contract for follow-up to hospitalization, or following those members with multiple hospitalizations?
- How are you analyzing social determinants issues that might be impacting unique populations like those with disabilities, in congregate care settings including populations in LTSS programs, adult foster homes, or recently discharged to home after a hospital or behavioral health inpatient stay?
- How are you taking a deeper dive on disparities in underserved populations (for example, seniors for whom English is not primary language who access all sorts of services at much lower rates and have higher burden of chronic disease in Oregon)?