Delivery System Network (DSN) Evaluation
May 28, 2021 Technical Assistance Webinar – Q&A

Health Services Advisory Group (HSAG) conducted a webinar on May 28, 2021, to provide technical assistance on 2021 DSN Evaluation Activities for coordinated care organizations (CCOs) and dental care organizations (DCOs). As a follow-up to the meeting, HSAG documented the questions asked by meeting attendees and worked with the Oregon Health Authority (OHA) to providers answers as listed below. HSAG modified the questions for grammatical clarity and consolidated similar questions to avoid redundancy.

#	Question	HSAG Response
1.	**Adding the additional data elements (i.e., OHA DSN Provider Groups and OHA DSN Provider Service Category) not only makes it difficult to extract, but for some CCOs we have to actually input the data first. For some this will be quite onerous. Is there a way the additional elements can be optional for the next few quarters until CCOs can get the data added?**	OHA has decided to not require CCOs and DCOs to use the MCE DSN Taxonomy Crosswalk for providing data in the 2021 DSN Provider Capacity Report at this time. Instead CCOs and DCOs should reference the crosswalk to gain an understanding of how OHA will categorize providers by specialization in relation to taxonomy codes. The crosswalk can also be referenced for validation purposes to ensure alignment of taxonomy specialty with provider reported specialty. Until further notice, the two new data fields included in the DSN Provider Capacity Report Template, OHA DSN Provider Groups and OHA DSN Provider Service Category, have been removed.
2.	**Do DCOs have to reference both the DCO Only tab and the CCO tabs when submitting DSN data directly to OHA, and then to CCOs?**	OHA has decided to not require CCOs and DCOs to use the MCE DSN Taxonomy Crosswalk for providing data in the DSN Provider Capacity Report submissions, but it should be referenced to understand OHA provider categorization by taxonomy code and may also be used for validation purposes. OHA and HSAG understand that the DCOs submit network data to OHA related to direct contracts with OHA, and also to CCOs related to CCO/DCO specific contracts. The "DCO Only" tab is specific to direct contracts with OHA, whereas the CCO tabs will be utilized to align with CCO reporting for respective subcontracted oral health providers. Please note that the oral health provider/service categories are different for direct DCO contract reporting versus CCO reporting. While DCOs are ultimately responsible for reporting deliverables for each of their respective contracts (e.g., contracts with CCOs versus OHA), OHA may work to align reporting for future DSN deliverables in consideration of avoidable redundancy.
3.	**What is the purpose of requiring CCOs to report on PCPB (PCP**	HSAG is aware that the PCPB category in the Taxonomy Crosswalk defaults to "Adult Primary Care." HSAG has

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	Both) ServCats if the description defaults to Adult Primary Care?	made revisions to the Taxonomy Crosswalk to ensure PCPB is categorized as "General Primary Care" to more accurately reflect services rendered to both adult and pediatric populations.
4.	**If we are providing Taxonomy already and you have the crosswalk what is the point in having us add those cross-walked values as well? Seems this is something that HSAG should handle when doing the analysis.**	OHA is now conducting the capacity analysis. The additional fields help crosswalk taxonomy codes to existing OHA Service and Provider categories in specific provider "buckets" (e.g., primary care, specialty care, etc.). These buckets should also be referenced by the CCOs/DCOs to enable more targeted provider network decision-making according to how OHA categorizes specific provider types.
5.	**For provider types that had originally been listed with two ServCats to illustrate that they serve both adult and pediatric populations, e.g. PCPP and PCPA, should CCOs recode those provider types into a single row affiliated with ProvCat for both, e.g. PCPB?**	Yes. The Provider Capacity Instructions were adjusted in 2020 to incorporate the "B (both)" indicator codes to minimize the need to list the same provider on multiple lines. CCOs and DCOs should list providers serving both adult and pediatric populations on a single line with the "B (both)" indicator codes.
6.	**We already have the NUCC Classification and NUCC Specialization which is what we currently use to evaluate. Why do we need the Taxonomy Crosswalk for our evaluations?**	HSAG and OHA appreciate any efforts to validate provider reported taxonomy codes, which is not currently a required validation factor. HSAG developed the Taxonomy Crosswalk using the National Uniform Claim Committee codes as a source of truth; however, OHA understands there are limitations related to the accuracy of taxonomy codes as reported and maintained by providers. While this limitation exists, taxonomy codes are determined to be the most effective way to capture provider specializations.
7.	**If we are modeling our own network adequacy and access against the new specialty categories, is it sensible to measure at the broader categories (e.g., MHPB) rather than the more granular Adult/Pediatric specs?**	The DSN Provider Capacity Report provider category codes referencing a "B (both)" indicator were intended to minimize the burden of duplicate reporting of providers servicing both pediatric and adult populations. OHA will be able to use these categories to assess network adequacy for both populations, but can also separate the data to assess by either adult or pediatric network adequacy. HSAG encourages CCOs and DCOs to consider the more granular adult versus pediatric specialties when monitoring network adequacy and making network adequacy decisions; however, CCOs/DCOs are allowed flexibility in how they analyze their data.
8.	**There are multiple errors in the current Crosswalk. If OHA corrects for these errors, will that**	The Taxonomy Crosswalk is a supplemental document to the DSN Provider Capacity Report Instructions; therefore, no error correction will result in restarting the clock for a 90-day notice period."

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9.	**The Taxonomy code is a flawed field to base specialty off of, especially for Dental. Our members don't access providers based off taxonomy code; they base it off the specialty.**	HSAG and OHA understand the limitations of taxonomy data in that they are reported point-in-time by providers and that specialties may change over time without taxonomy codes being changed by providers to reflect their current specialty. OHA's use of taxonomy codes will assist the agency in analyses of providers at a more granular level with the caveat that not all taxonomy codes are able to be fully validated or are up to date. There is no requirement to use the taxonomy code in provider directories, but CCOs/DCOs should ensure consistency in how specialties are reported to OHA and displayed for members. If inconsistencies are present, CCOs/DCOs should work to determine why the inconsistency exists (e.g., taxonomy code not updated to reflect current specialty) and make corrections as necessary.
10.	**Having the crosswalk be import-friendly would be a big help. Otherwise, it would be a manual process to use it to populate the provider group/service category fields.**	Because OHA has decided to not require the completion of the two new data fields in the DSN Provider Capacity Report Template in 2021, CCOs/DCOs should use the DSN MCE Taxonomy Crosswalk as a reference to understand how OHA will categorize specific provider types, as well as for validation purposes to confirm provider reported specialties align with reported taxonomy codes. OHA will determine whether to adjust the Taxonomy Crosswalk to ensure it is import friendly for any future DSN Provider Capacity Report submissions in which it may be required.
11.	**Should the endodontics issue be addressed in the narrative? Also, on the CCO Specialty tab, OHPB is not included and all Oral Health Providers are listed as ProvCat 01 (including denturists and hygienists).**	The provision of endodontics by primary dental providers can be addressed through the DSN Provider Narrative. HSAG is currently working with OHA to further refine the Taxonomy Crosswalk and will post the revision by June 18, 2021 on the OHA contract forms webpages for CCOs and DCOs. OHA consideration will be given to additional alignment of CCO/DCO reporting categories for future reporting.
12.	**The Narrative instructions just released on the 17th still says 90%. Will that be updated?**	The Narrative Instructions were modified on May 26, 2021 to reflect the current standard of 100% timely access. The updated Instructions are available on CCO and DCO Contract Forms webpages contained within OHA's website. The document is titled *DSN Provider Narrative Template and Instructions 05-2021*.
13.	**How do you address members with out of state addresses? Also, foster kids may be in our system with an address out of our area but are currently placed within our**	OHA is working internally to extract foster children from member data to be provided to HSAG for time and distance analyses. To the extent other anomalies are found, those instances will be further assessed by OHA in conjunction

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	coverage area. We are generally very close to a 100% but can have some members spread across the state, which can skew our access numbers to below 100%.	with CCOs and DCOs to determine the nature of such discrepancies.
14.	**Certified Health Care Interpreters (HCIs) are listed as organizational only. How can we include HCI in the capacity report who are CCO staff and available to attend appointments and provide services to our members?**	For the purposes of the DSN Provider Capacity Report, Health Care Interpreters are considered a service, and not individual practitioners. Information regarding CCO staff serving as health care interpreters can be reported in the DSN Provider Narrative.
15.	**We have not received guidance from OHA regarding whether TeleHealth_Ind should encompass any type of virtual/electronic communication and service, even for practitioners who provide communications but not full-fledged virtual visits. Lacking this guidance, should CCOs report "Y" for all individual providers who have the ability to provide any telehealth service?**	The TeleHealth_Ind field is meant to capture whether each provider is able to provide virtual visits using telehealth technology. CCOs and DCOs should report "Y" in the DSN Provider Capacity Report for providers that offer virtual visits using telehealth technology. Additional details regarding providers' abilities to provide TeleHealth related communications can be reported in the DSN Provider Narrative.