Oregon Health Authority

2022 Delivery System Network (DSN) Evaluation Protocol

April 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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1. 2022 DSN Evaluation Overview

Background

Federal and State regulations governing Medicaid services require each managed care contractor to maintain a network of appropriate health care providers to ensure all services covered under the State plan are available and accessible to members in a timely manner. Oregon Health Authority (OHA) contracts with 16 coordinated care organizations (CCOs) and five dental care organizations (DCOs), collectively referred to as managed care entities (MCEs), to deliver managed care services for Oregon Health Plan (OHP) members. Each contractor must submit documentation to the State Medicaid authority demonstrating the contractor's capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care.[1-1] OHA contracted with Health Services Advisory Group, Inc. (HSAG) to evaluate whether the MCEs are meeting state-established network standards.

Objective of Conducting the DSN Evaluation

The primary objective of HSAG's review is to provide meaningful information to OHA and the CCOs regarding the adequacy of CCO provider networks and monitoring activities as well as compliance with relevant State and federal requirements. HSAG will:

- Assess the completeness of MCE responses provided in the DSN Narrative Reports with respect to meeting the criteria set forth in Exhibit G of the MCE contract.
- Assess the geographic distribution of providers relative to member populations and evaluate the extent to which MCEs met the OHA-defined time and distance access standards.
- Analyze data submitted in MCE Provider Capacity Reports to draw conclusions regarding the quality of data and reporting, provider network capacity, and provider accessibility.

To accomplish its objective, and based on the results of collaborative planning with OHA, HSAG will develop a narrative data collection and evaluation tool, obtain OHA Provider Capacity reports and quarterly data, and conduct an analysis network adequacy metrics to CCO delivery system networks.

[1-1] See Title 42 Code of Federal Regulations (42 CFR) §438.206 and §438.207; Oregon Administrative Rules (OAR) 410-141-3515.

Timeline

The 2022 DSN Evaluation timeline, including the schedule of deliverables, is identified in Table 1-1.

Table 1-1—DSN Evaluation Activities Timeline

Activity	Responsible Entity	Time Frame
Submit quarterly DSN Provider Capacity Reports to OHA	MCEs	Quarterly*
Submit Annual DSN Narrative Reports to OHA	MCEs	August 1, 2022**
Submit second quarter (4/1/22-6/30/22) DSN Provider Capacity Reporting to HSAG	OHA	October 14, 2022
Conduct annual DSN Narrative Report review and time and distance analysis	HSAG	August–November 2022
Provide draft 2022 Annual DSN Evaluation Report to OHA/MCEs for review and feedback	HSAG	December 2022
Finalize and distribute 2022 Annual DSN Evaluation Report	HSAG	January 2023

*MCEs are contractually required to submit a quarterly DSN Provider Capacity Report on the 45th day following the end of each quarter and an Annual DSN Narrative Report on or before July 31 of each year.
**The 2022 submission date for the Annual DSN Narrative Report submission was extended to August 1, 2022, per OHA, due to July 31, 2022 falling on a Sunday.

Annual DSN Narrative Report

Each MCE is required to submit an Annual DSN Narrative Report that includes comprehensive narrative responses and analysis demonstrating how the MCE ensures, monitors, and evaluates network adequacy. The DSN Narrative Report is separated into four categories: description of the delivery network and adequacy, description of members and membership needs, community coordination, and network response strategy.

DSN Narrative Report Categories

The *Description of the Delivery Network and Adequacy* category demonstrates the MCE's process for monitoring the adequacy of its network and using information collected to inform its network adequacy decision-making. Elements within the category address the tools and systems used, use of REALD data, types of monitoring conducted in relation to contractual obligations, use of direct feedback, mitigation of impacts from provider terminations, and network relationships with available Indian Health Service (IHS) and Tribal Health Services (THS) within or near the MCE's service area.

The *Description of Members and Membership Needs* category provides details of the MCE's approach to monitoring and considering the characteristics and needs of its membership when making network adequacy decisions and adjustments. Elements within the category are designed to collect information on the MCE's membership in terms of physical and mental disabilities and special health care needs, linguistic and cultural needs, grievances, workforce readiness to provide culturally and linguistically appropriate services, and Medicaid and full-benefit/dual-eligible (FBDE) enrollment and trends for utilization of services.

The *Community Coordination* category describes the MCE's coordination efforts with resources and institutions within its local community to develop and maintain a capable workforce, other data sources drawn upon to support its strategies, and use of performance metric data to monitor and enhance its network adequacy.

The *Network Response Strategy* category provides insight into the MCE's methods used to identify barriers to network adequacy, implement interventions to resolve barriers, evaluate the efficacy of any interventions, and actions taken to address any previously identified areas for improvement.

DSN Narrative Reporting Instructions

To complete the DSN Narrative Report, MCEs must complete the provided DSN Narrative Template tool and submit it as a Word document. MCEs may either embed supporting documentation or provide supporting documentation separately. Narrative responses should directly answer each element and must indicate what documentation (e.g., policies and procedures, reports, data sets, etc.) has been provided to support each response.

Quarterly DSN Provider Capacity Report

The DSN Provider Capacity Report activity is managed by OHA. Each MCE's quarterly submission of data must be compiled following the template and instructions provided by OHA, as failure to do so may result in the rejection of the MCE's report submission and lead to required resubmission. OHA will evaluate each MCE's quarterly DSN Provider Capacity Report, focusing on the following three domains:

1. **Quality of DSN Provider Capacity Reporting**—The MCE's ability to provide complete and accurate provider network data in the required format.
2. **Provider Network Capacity**—The underlying infrastructure of each MCE's DSN, including whether health services are available to members through a sufficient supply and variety of providers.
3. **Provider Accessibility**—The degree to which contracted services are accessible to each MCE's member population.

OHA will submit the results of its second quarter 2022 DSN Provider Capacity Report analyses to HSAG no later than October 14, 2022. HSAG will review, summarize, aggregate, and report on findings

associated with the MCEs in the 2022 DSN Evaluation Report. HSAG will not conduct an independent assessment of the DSN Provider Capacity Reports.

2. Reporting and Scoring

Overview

The 2022 Annual CCO & DCO DSN Evaluation Reports will be based on HSAG's assessment of each MCE's 2022 DSN Narrative Report and second quarter DSN Provider Capacity Report. HSAG will present evaluation results in aggregate reports for CCOs and DCOs, including appendices with results for individual MCEs. Each report will include:

- A comprehensive summary of evaluation results, including general assessments.
- Findings and recommended actions for each MCE to achieve State network adequacy standards.
- Overarching recommendations to OHA, including any need for technical assistance or clarification regarding OHA requirements.

Prior to finalizing each 2022 Annual DSN Evaluation Report, HSAG will submit the aggregate CCO and DCO draft reports to OHA and individual results appendices to MCEs for a two-week review and feedback period. Data resubmissions will not be permitted. HSAG will consider feedback and incorporate changes as appropriate.

DSN Narrative Report Evaluation and Scoring Criteria

HSAG will review and score each MCE's DSN Narrative Evaluation tool, based on the narrative response requirements identified Appendix A (i.e., CCO) and Appendix B (i.e., DCO) and scoring criteria defined in Table 2-1. Elements will receive a score ranging from 1 (*Met*) to 0 (*Not Met*) with a score of 0.5 for elements evaluated as *Partially Met*. All element scores will then be aggregated into a category score and an overall summary score.

Table 2-1—DSN Narrative Report Scoring Criteria

Score	Rating	Rating Description
1.0	*Met*	Indicates *all* of the following components were present and complete: • Narrative response fully addressed reporting requirements of the element; and • Required documentation and/or data (when applicable) was: − Submitted with narrative response − Relevant to the element and/or review period, and − Sufficient to demonstrate compliance with element.
0.5	*Partially Met*	Indicates one or more of the following components were missing or incomplete:

		• Narrative response fully addressed reporting requirements of the element; and • Required documentation and/or data (when applicable) was: − Submitted with narrative response − Relevant to the element and/or review period, and − Sufficient to demonstrate compliance with element.
0.0	*Not Met*	Indicates *all* of the following: • Narrative response did not address the element or stated that a required activity was not conducted; and • Required documentation and/or data (when applicable) was not: − Submitted with the narrative response − Relevant to the element and/or review period, and − Insufficient to demonstrate compliance with element.

Table 2-2 identifies the DSN Narrative Report categories, the number of reporting elements associated with each category, and the maximum number of points possible for scoring the MCEs' compliance with the elements.

Table 2-2—DSN Narrative Report Categories

Category Number	Category Description	CCO		DCO	
		Number of Elements	Maximum Points	Number of Elements	Maximum Points
1	Description of the Delivery Network and Adequacy	32	32.0	31	31.0
2	Description of Members and Membership Needs	12	12.0	12	12.0
3	Community Coordination	4	4.0	4	4.0
4	Network Response Strategy	6	6.0	6	6.0
	Totals	**54**	**54.0**	**53**	**53.0**

Time and Distance Analysis

Using member data provided by OHA and each DSN Provider Capacity Report, HSAG will conduct the time and distance analysis using the following key measures and the State time and distance thresholds listed in Table 2-3.

- Percentage and number of members living within the time and distance standards.

- Average time (in minutes) and distance (in miles) to the nearest three providers for each provider type evaluated.

Table 2-3—DSN Time and Distance Standards

Geographic Classification	Definition	Time Standard	Distance Standard	Percentage of Overall Member Access Standard
Urban	A geographic area that is less than 10 map miles from a population center of 30,000 people or more.	30 Minutes	30 Miles	100%
Rural	A geographic area that is 10 or more map miles from a population center of 30,000 people or less.	60 Minutes	60 Miles	100%

DSN Provider Capacity Report Evaluation and Scoring Criteria

The DSN Provider Capacity Report is an inventory of each individual (i.e., physician, mid-level practitioner, or other practitioners), facility, or business, whether employed by or under subcontract with an MCE, or paid fee-for-service, that agrees to provide the described services, or items, to Medicaid MCE members. MCEs are required to follow a reporting template and instructions including the appropriate provider, facility, or business provider categories and associated service categories and field values. OHA will process, clean, and evaluate data provided by MCEs to assess the geographic distribution of MCE providers listed in Table 2-4 and Table 2-5 by MCE type.

Table 2-4—DSN CCO Service Category Descriptions and Field Values

Individual Practitioners		Facility, Clinic, Business, or Other Service Providers	
MHPA	Mental Health Provider, Adult	FQHC	Federally Qualified Health Centers
MHPP	Mental Health Provider, Pediatric	HOSP	Hospital
MHPB	Mental Health Provider, Both (Adult and Pediatric)	HPSY	Hospital, Acute Psychiatric Care
OHPA	Oral Health Provider, Adult	IHS/ THS	Indian Health Service and Tribal Health Services
OHPP	Oral Health Provider, Pediatric	PCPCH	Patient-Center Primary Care Home
OHPB	Oral Health Provider, Both, (Adult and Pediatric)	RHC	Rural Health Centers
PCPA	Primary Care Provider, Adult	RX	Pharmacies
PCPP	Primary Care Provider, Pediatric	SNF	Post-hospital Skilled Nursing Facility
PCPB	Primary Care Provider, Both	UCC	Urgent Care Center

Individual Practitioners		Facility, Clinic, Business, or Other Service Providers	
	(Adult and Pediatric)		
SPA	Specialty Practitioner, Adult		
SPP	Specialty Practitioner, Pediatric		
SPB	Specialty Practitioner, Both (Adult and Pediatric)		
SUDA	Substance Use Disorder Provider, Adult		
SUDP	Substance Use Disorder Provider, Pediatric		
SUDPB	Substance Use Disorder Provider, Both (Adult and Pediatric)		

Table 2-5—DSN DCO Service Category Descriptions and Field Values

Individual Practitioners		Facility, Clinic, Business, or Other Service Providers	
DEN	Denturist	EDSC	Emergency Dental Services Clinic
END	Endodontist	FQHC	Federally Qualified Health Centers
EPDH	Expanded Practice Dental Hygienist	IHS/ THS	Indian Health Service and Tribal Health Services
ODO	Orthodontist & Dentofacial Orthopedics	PCHD	Public/County Health Department
OMP	Oral & Maxillofacial Pathologist	RHC	Rural Health Centers
OMS	Oral & Maxillofacial Surgeon		
PER	Periodontist		
PCDA	Primary Care Dentist, Adult		
PCDP	Primary Care Dentist, Pediatric		
PCDP	Primary Care Dentist, Both (Adult and Pediatric)		
PRO	Prosthodontics		
RDH	Registered Dental Hygienist		

3. Documentation Submission

All DSN related materials must be submitted directly to OHA's Health Systems Division Team at its respective MCE email address:

CCO Submission: CCO.MCODeliverableReports@dhsoha.state.or.us

DCO Submission: DCODeliverableReports@dhsoha.state.or.us

These materials include both quarterly Provider Capacity reports and the annual DSN narrative evaluation (i.e., tool and supplemental documentation). When submitting documents, each MCE should ensure document file names reflect the contents of the file. Large files or large numbers of files should be submitted as .zip files. Difficulties or questions regarding DSN deliverable submissions can be directed to the following OHA personnel:

Cheryl Henning
OHA Health Systems Division, CCO Contract Administrator
503.593.6894
Cheryl.L.Henning@dhsoha.state.or.us

Cortnee Whitlock
OHA Quality Assurance & Compliance Specialist
503.801.2705
Cortnee.Whitlock@dhsoha.state.or.us

John Levear
OHA Compliance Data Analyst
503.314.8817
John.W.Levear@dhsoha.state.or.us

Carrie Williamson
OHA Quality Assurance & Compliance Specialist
971.701.9527
carrie.williamson2@dhsoha.state.or.us

4. Appendix A: CCO Narrative Report Elements

Description of the Delivery Network and Adequacy

Element #	Category Elements
Element 1.	
1.1	CCO describes methodologies and defines geocoding systems and/or other mapping applications used to calculate average travel time (minutes), average distance (miles), and percentage of members living within the state-established time and distance standards for the CCO's relevant geographic classification(s) within its service area. The methodology must include a description of data elements used to conduct travel time and distance monitoring (e.g., member's physical address to the provider's location). CCO describes the source of the data elements used to determine the member and provider locations, how often the data is updated, and process(es) used to update data (e.g., via a supporting policy or procedure).
1.2	The CCO describes its process for determining provider specialties (e.g., provider self-identifies when credentialed, MCE designates based on specialty listed, etc.), source of the data (e.g., credentialing files), how often the data is updated, and how the CCO monitors its specialist providers (i.e., whether the CCO monitors specialists by provider type, service type, or as a single group).

Element #	Category Elements
Element 2.	
CCO submits its time and distance calculations (geocoding maps, tables, Microsoft Excel, or a consolidated report) for **each** of the provider types in elements 2.1 through 2.12 based the CCO's relevant geographic classification(s) within its service area. CCO calculations must address all of the following specifications: a. Average time (in minutes), b. Average distance (in miles),and c. Percentage of members living within the time and distance standards. CCO indicates whether it meets or does not meet the time and distance standard for rural and urban designations for each of the following service categories. Where the CCO does not meet the standard, it must provide a description of how member access below the standard was and/or is currently being addressed to achieve compliance and the time frame for resolution of the deficiency.	
2.1	• Primary Care Provider, Adult • Primary Care Provider, Pediatric • Primary Care Provider, Both Combined (Rendering care ages 0 to 99)
2.2	• Specialty Practitioner, Adult • Specialty Practitioner, Pediatric • Specialty Practitioner, Both Combined (Adult and Pediatric)
2.3	• Mental Health Provider, Adult • Mental Health Provider, Pediatric • Mental Health Provider, Both Combined (Adult and Pediatric)
2.4	• Substance Use Disorder Provider, Adult • Substance Use Disorder Provider, Pediatric • Substance Use Disorder Provider, Both Combined (Adult and Pediatric)
2.5	• Oral Health Provider, Adult • Oral Health Provider, Pediatric • Oral Health Provider, Both Combined (Adult and Pediatric)
2.6	Federally Qualified Health Centers
2.7	Hospital
2.8	Hospital, Acute Psychiatric Care
2.9	Pharmacies
2.10	Indian Health Service and Tribal Health Services

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Element #	Category Elements
2.11	Rural Health Centers
2.12	Post-Hospital Skilled Nursing Facility
2.13	Urgent Care Centers
Element 3.	
3.1	CCO describes its established mechanism for monitoring timely access to care to ensure scheduled or rescheduled physical, oral, and behavioral health member appointments are timely for emergent, urgent, and routine/well-care visits. Answers should include provider types included in monitoring, monitoring method including frequency, and process for addressing providers failing to meet network access standards (e.g., via a policy or procedure). CCO describes how the data is used in a meaningful manner to facilitate network adequacy decisions.
3.2	CCO describes its mechanism for monitoring hours of operation, including member access during non-standard business hours, weekends, nights, and holidays. The CCO should address emergent, urgent, and routine/well-care visit services.
Element 4.	
4.1	CCO describes its mechanism for monitoring provider-to-member ratio data as well as the authoritative source(s) it uses to determine the adequacy of these ratios. Answers should include provider types included in monitoring, ratio standards used, monitoring method, and frequency of monitoring activities. CCO describes how the data is used in a meaningful manner to facilitate network adequacy decisions.
4.2	CCO submits provider-to-member ratio data for all provider types it monitors as part of its network adequacy decision-making (e.g., via a ratio data report).
Element 5.	
5.1	CCO describes its mechanism for monitoring non-emergency transportation (NEMT) utilization data for members with and without disabilities or special needs to identify barriers to access. CCO describes how the data is used in a meaningful manner to facilitate network adequacy decisions.
Element 6.	
6.1	CCO describes its mechanism for monitoring network adequacy by *member* demographics, including race, ethnicity, language, and disability (e.g., REALD). CCO describes how the data is used in a meaningful manner to facilitate network adequacy decisions.
6.2	CCO describes its mechanism for monitoring network adequacy by *provider* demographics, including race, ethnicity, and language. CCO describes how the data is used in a meaningful manner to facilitate network adequacy decisions.

Element 7.	
CCO describes its mechanism for monitoring data and feedback from each source listed in elements listed below, how it ensures broad representation of community/member voices, and how it meaningfully uses the information to inform network adequacy decisions. If the CCO does not consider the indicated source(s) when making network adequacy decisions, it must provide a rationale for the exclusion.	
7.1	Grievance and appeal data related to access, availability, or other network considerations pertinent to the provision of culturally and linguistically appropriate and trauma-informed care.
7.2	Survey data (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS], Mental Health Statistics Improvement Program [MHSIP]. etc.).
7.3	Community Advisory Council feedback or other input.
7.4	Provider and CCO staff feedback, including interdisciplinary care teams.
7.5	Separate from the above mechanisms, CCO describes how it ensures member input is used in a meaningful manner to facilitate network adequacy decisions.
Element 8.	
8.1	CCO provides the names of any and all providers terminated from the network, the reason for each termination, and the number of members impacted by the termination(s).
8.2	CCO describes how it mitigated impacts or potential impacts to members as a result of any provider terminations. If no providers were terminated, CCO describes the actions it would take to mitigate impacts to members as a result of future terminations.
Element 9.	
9.1	CCO describes its network relationship with any Indian Health Service (IHS) and Tribal Health Services (THS) within or near its service area. Alternatively, the CCO provides evidence that no such providers are located within or reasonably near its service area or are otherwise not offering services.
9.2	CCO submits calculations to identify the total number of members eligible to receive services through participating IHS/THS providers areas well as the total numbers of participating providers broken out by service type.
9.3	CCO describes its mechanism for monitoring access to covered services for American Indian/Alaska Native (AI/AN) members, including timely access rates for AI/AN members.

Description of Members and Membership Needs

Element #	Category Elements
Element 10.	
10.1	CCO describes how it actively identifies members with physical and mental disabilities and special health care needs (SHCN) and submits data to demonstrate this subset of its member population (e.g., via a current report).
10.2	CCO describes how it monitors, interprets, and utilizes data regarding members with disabilities and SHCN in a meaningful manner to facilitate network adequacy decisions.
Element 11.	
11.1	CCO describes how it actively identifies prevalence of disease across its member population and submits data to demonstrate this prevalence (e.g., via a current report).
11.2	CCO describes how it monitors, interprets, and utilizes disease prevalence data across its membership in a meaningful manner to facilitate network adequacy decisions, including use of REALD data.
Element 12.	
12.1	CCO describes how it actively identifies the linguistic and cultural needs of its members and submits data to demonstrate this subset of its member population (e.g., via a current report). The CCO's answer should address the use of REALD data.
12.2	CCO describes how it monitors, interprets, and utilizes member linguistic and cultural needs data and REALD data in a meaningful manner to facilitate network adequacy decisions.
Element 13.	
13.1	CCO describes how it actively collects, monitors, and interprets data from OHA, grievances and appeals, training processes, and relevant reports on workforce capacity and diversity to assess the readiness of its provider network to provide member services in a culturally and linguistically appropriate and trauma-informed manner.
13.2	CCO describes how it utilizes the data sources relevant to the provision of culturally and linguistically appropriate care in a meaningful manner to facilitate network adequacy and workforce development decisions.
Element 14.	
14.1	CCO describes how it monitors current and anticipated Medicaid and FBDE member enrollment and submits data to demonstrate these populations (e.g., via a current report).

Element #	Category Elements
14.2	CCO describes how current and anticipated Medicaid and FBDE member enrollment data is used in a meaningful manner to facilitate network adequacy decisions.
Element 15.	
15.1	CCO describes how it collects and monitors current and expected service utilization data.
15.2	CCO describes how current and expected service utilization data is used in a meaningful manner to facilitate network adequacy decisions.

Community Coordination

Element #	Category Elements
Element 16.	
16.1	CCO describes strategies it has taken and plans to implement to work with local communities, local and state educational resources, and other OHA resources, including financial incentives, to develop an action plan to ensure its workforce is prepared to provide physical, behavioral, and oral health services to the members within the CCO's service area in a manner that is culturally and linguistically appropriate and trauma informed.
16.2	CCO describes any data sources it uses to support such strategies, including the nature of the data, frequency with which the data is updated and reviewed/validated, and how the data is analyzed.
Element 17.	
17.1	CCO describes how it uses performance metrics to monitor network adequacy, including what the metrics are, the frequency of evaluation, and how monitoring results are used to address deficiencies within the network.
17.2	CCO describes what performance data it shares with its network (both aggregate and individual data) and what actions are taken to improve network adequacy as a result.

Network Response Strategy

Element #	Category Elements
Element 18.	
18.1	CCO provides its methodology for identifying barriers to network adequacy and/or member network access through both quantitative and qualitative indicators.
18.2	CCO describes any existing current barriers to network adequacy and/or gaps in its provider network identified in the course of its monitoring cycles, including

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Element #	Category Elements
	but not limited to the elements listed in the *Description of the Delivery Network and Adequacy* category (i.e., time and distance standards, provider-to-member ratios, timeliness, etc.). If no deficiencies were identified, the CCO should describe the relevant processes it would follow to correct the issue.
18.3	CCO describes the immediate short-term interventions it will or would implement to correct the identified deficiencies as well as the time frames for such interventions.
18.4	CCO describes the long-term interventions it will or would implement to fill network gaps and resolve barriers or changes in future capacity needs, including the time frames for such interventions.
18.5	CCO describes outcome measures for evaluating the efficacy of its interventions or the processes it would follow for creating such measures.
Element 19.	
19.1	CCO describes any findings identified in the prior year's DSN Evaluation and provides a brief description of how previously identified issues have been corrected.

5. Appendix B: DCO Narrative Report Elements

Description of the Delivery Network and Adequacy

Element #	Category Elements
Element 1.	
1.1	DCO describes methodologies and defines geocoding systems and/or other mapping applications used to calculate average travel time (minutes), average distance (miles), and percentage of members living within the state-established time and distance standards for the DCO's relevant geographic classification(s) within its service area. The methodology must include a description of data elements used to conduct travel time and distance monitoring (e.g., member's physical address to the provider's location). DCO describes the source of the data elements used to determine the member and provider locations, how often the data is updated, and process(es) used to update data (e.g., via a supporting policy or procedure).
1.2	The DCO describes its process for determining provider specialties (e.g., provider self-identifies when credentialed, MCE designates based on specialty listed, etc.), source of the data (e.g., credentialing files), how often the data is updated, and how the DCO monitors its specialist providers (i.e., whether the DCO monitors specialists by provider type, service type, or as a single group).

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Element #	Category Elements
Element 2.	
DCO submits its time and distance calculations (geocoding maps, tables, Microsoft Excel, or a consolidated report) for **each** of the provider types in elements 2.1 through 2.15 based the DCO's relevant geographic classification(s) within its service area. DCO calculations must address all of the following specifications: d. Average time (in minutes), e. Average distance (in miles), and f. Percentage of members living within the time and distance standards. DCO indicates whether it meets or does not meet the time and distance standard for rural and urban designations for each of the following service categories. Where the DCO does not meet the standard, it must provide a description of how member access below the standard was and/or is currently being addressed to achieve compliance and the time frame for resolution of the deficiency.	
2.1	• Primary Care Dentist, Adult • Primary Care Dentist, Pediatric • Primary Care Dentist, Both Combined (Rendering care ages 0 to 99)
2.2	Denturist
2.3	Endodontist
2.4	Expanded Practice Dental Hygienist
2.5	Periodontist
2.6	Oral & Maxillofacial Surgeon
2.7	Orthodontist & Dentofacial Orthopedics
2.8	Hospital, Acute Psychiatric Care
2.9	Prosthodontics
2.10	Registered Dental Hygienist
2.11	Emergency Dental Services Clinic
2.12	Federally Qualified Health Centers
2.13	Indian Health Service and Tribal Health Services
2.14	Public/County Health Department
2.15	Rural Health Centers
Element 3.	

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Element #	Category Elements
3.1	DCO describes its established mechanism for monitoring timely access to care to ensure scheduled or rescheduled oral health member appointments are timely for emergent, urgent, and routine/well-care visits. Answers should include provider types included in monitoring, monitoring method including frequency, and process for addressing providers failing to meet network access standards (e.g., via a policy or procedure). DCO describes how the data is used in a meaningful manner to facilitate network adequacy decisions.
3.2	DCO describes its mechanism for monitoring hours of operation, including member access during non-standard business hours, weekends, nights, and holidays. The DCO should address emergent, urgent, and routine/well-care visit services.
Element 4.	
4.1	DCO describes its mechanism for monitoring provider-to-member ratio data as well as the authoritative source(s) it uses to determine the adequacy of these ratios. Answers should include provider types included in monitoring, ratio standards used, monitoring method, and frequency of monitoring activities. DCO describes how the data is used in a meaningful manner to facilitate network adequacy decisions.
4.2	DCO submits provider-to-member ratio data for all provider types it monitors as part of its network adequacy decision-making (e.g., via a ratio data report).
Element 5.	
5.1	DCO describes its mechanism for monitoring network adequacy by *member* demographics, including race, ethnicity, language, and disability (e.g., REALD). DCO describes how the data is used in a meaningful manner to facilitate network adequacy decisions.
5.2	DCO describes its mechanism for monitoring network adequacy by *provider* demographics, including race, ethnicity, and language. DCO describes how the data is used in a meaningful manner to facilitate network adequacy decisions.
Element 6.	
DCO describes its mechanism for monitoring data and feedback from each source listed in elements listed below, how it ensures broad representation of community/member voices, and how it meaningfully uses the information to inform network adequacy decisions. If the DCO does not consider the indicated source(s) when making network adequacy decisions, it must provide a rationale for the exclusion.	

6.1	Grievance and appeal data related to access, availability, or other network considerations pertinent to the provision of culturally and linguistically appropriate and trauma-informed care.
6.2	Provider and DCO staff feedback, including interdisciplinary care teams (as applicable).
6.3	Separate from the above mechanisms, DCO describes how it ensures member input is used in a meaningful manner to facilitate network adequacy decisions.
Element 7.	
7.1	DCO provides the names of any and all providers terminated from the network, the reason for each termination, and the number of members impacted by the termination(s).
7.2	DCO describes how it mitigated impacts or potential impacts to members as a result of any provider terminations. If no providers were terminated, DCO describes the actions it would take to mitigate impacts to members as a result of future terminations.
Element 8.	
8.1	DCO describes its network relationship with any Indian Health Service (IHS) and Tribal Health Services (THS) within or near its service area. Alternatively, the DCO provides evidence that no such providers are located within or reasonably near its service area or are otherwise not offering services.
8.2	DCO submits calculations to identify the total number of members eligible to receive services through participating IHS/THS providers areas well as the total numbers of participating providers broken out by service type.
8.3	DCO describes its mechanism for monitoring access to covered services for American Indian/Alaska Native (AI/AN) members, including timely access rates for AI/AN members.

Description of Members and Membership Needs

Element #	Category Elements
Element 9.	
9.1	DCO describes how it actively identifies members with physical and mental disabilities and special health care needs (SHCN) and submits data to demonstrate this subset of its member population (e.g., via a current report).
9.2	DCO describes how it monitors, interprets, and utilizes data regarding members with disabilities and SHCN in a meaningful manner to facilitate network adequacy decisions.

Element #	Category Elements
Element 10.	
10.1	DCO describes how it actively identifies prevalence of disease across its member population and submits data to demonstrate this prevalence (e.g., via a current report).
10.2	DCO describes how it monitors, interprets, and utilizes disease prevalence data across its membership in a meaningful manner to facilitate network adequacy decisions, including use of REALD data.
Element 11.	
11.1	DCO describes how it actively identifies the linguistic and cultural needs of its members and submits data to demonstrate this subset of its member population (e.g., via a current report). The DCO's answer should address the use of REALD data.
11.2	DCO describes how it monitors, interprets, and utilizes member linguistic and cultural needs data and REALD data in a meaningful manner to facilitate network adequacy decisions.
Element 12.	
12.1	DCO describes how it actively collects, monitors, and interprets data from OHA, grievances and appeals, training processes, and relevant reports on workforce capacity and diversity to assess the readiness of its provider network to provide member services in a culturally and linguistically appropriate and trauma-informed manner.
12.2	DCO describes how it utilizes the data sources relevant to the provision of culturally and linguistically appropriate care in a meaningful manner to facilitate network adequacy and workforce development decisions.
Element 13.	
13.1	DCO describes how it monitors current and anticipated Medicaid and FBDE member enrollment and submits data to demonstrate these populations (e.g., via a current report).
13.2	DCO describes how current and anticipated Medicaid and FBDE member enrollment data is used in a meaningful manner to facilitate network adequacy decisions.
Element 14.	
14.1	DCO describes how it collects and monitors current and expected service utilization data.
14.2	DCO describes how current and expected service utilization data is used in a meaningful manner to facilitate network adequacy decisions.

Community Coordination

HSAG HEALTH SERVICES ADVISORY GROUP

Element #	Category Elements
Element 15.	
15.1	DCO describes strategies it has taken and plans to implement to work with local communities, local and state educational resources, and other OHA resources, including financial incentives, to develop an action plan to ensure its workforce is prepared to provide oral health services to the members within the DCO's service area in a manner that is culturally and linguistically appropriate and trauma informed.
15.2	DCO describes any data sources it uses to support such strategies, including the nature of the data, frequency with which the data is updated and reviewed/validated, and how the data is analyzed.
Element 16.	
16.1	DCO describes how it uses performance metrics to monitor network adequacy, including what the metrics are, the frequency of evaluation, and how monitoring results are used to address deficiencies within the network.
16.2	DCO describes what performance data it shares with its network (both aggregate and individual data) and what actions are taken to improve network adequacy as a result.

Network Response Strategy

Element #	Category Elements
Element 17.	
17.1	DCO provides its methodology for identifying barriers to network adequacy and/or member network access through both quantitative and qualitative indicators.
17.2	DCO describes any existing current barriers to network adequacy and/or gaps in its provider network identified in the course of its monitoring cycles, including but not limited to the elements listed in the *Description of the Delivery Network and Adequacy* category (i.e., time and distance standards, provider-to-member ratios, timeliness, etc.). If no deficiencies were identified, the DCO should describe the relevant processes it would follow to correct the issue.
17.3	DCO describes the immediate short-term interventions it will or would implement to correct the identified deficiencies as well as the time frames for such interventions.
17.4	DCO describes the long-term interventions it will or would implement to fill network gaps and resolve barriers or changes in future capacity needs, including the time frames for such interventions.
17.5	DCO describes outcome measures for evaluating the efficacy of its interventions or the processes it would follow for creating such measures.

Element #	Category Elements
Element 18.	
18.1	DCO describes any findings identified in prior year’s DSN Evaluation and provides a brief description of how previously identified issues have been corrected.