Delivery System Network (DSN) Evaluation
Frequently Asked Questions (FAQ) – Updated May 28, 2024

No.	Question	Answer
1	Is average travel time to providers still a requirement? I thought it was based on the OAR 410.	Although CCO compliance with the network adequacy standards, defined in OAR 410-141-3515 (8), is assessed based on CCO's compliance with time **or** distance standards, HSAG calculates average travel time as part of its time and distance analysis. Per OAR 410-141-3515 (9) "all MCE acceptable travel time and distance monitoring must assess the geographic distribution of providers relative to members and calculate **driving time and distance** from the member's physical address to the provider's location through the use of geocoding software or other mapping applications."
2	Is the CMS urbanicity shape file available publicly, or is it provided to the CCOs?	The urbanicity shape file is available on the OHP Network Adequacy web page within the Methodology Documentation section, in addition to additional resources. LINK: https://www.oregon.gov/oha/hsd/ohp/pages/network.aspx.
3	How will the increase of Telehealth Only providers (specifically MH) be credited?	Currently, the network adequacy standard for time and distance does not adjust for *telehealth only* providers. However, the CCOs are able to address the use of telehealth providers and services through OHA's exception process. OHA and HSAG acknowledge the increased use of telehealth-only providers for many services and are working to determine how to assess such network dynamics. In the meantime, it is expected that CCOs monitor the use of telehealth services, including utilization rates and other data, to help inform their network monitoring efforts. CCOs should use the DSN Narrative to explain such strategies within relevant narrative elements (e.g., Telehealth Modalities) and Section 4 (i.e., identifying time/distance access barriers, identifying telehealth options as a suitable tool to address such barriers including internet speed/phone reception availability, and assessing the impacts of such telehealth modalities).

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4	Wouldn't telehealth be considered "zero" miles away? To clarify, post-COVID-19 pandemic, many providers transitioned to a telehealth only model where their service is being provided from their private residence. Their private residence is not published in our directory and is not included in DSM either, because of the geocoding of the DSM, therefore it is not necessarily clear for how we get credit for having those providers within our network. Members can access care from those providers, but they transition to providing care from their home via telehealth only. Just wondering how that will be considered in the various parts of network adequacy because even change over Q1 2023 to 2024 they have transitioned from brick and mortar to telehealth only provision, therefore, it would look like we lost providers.	Please see the response to Question #3. In addition to the time and distance assessment, HSAG conducts a review of provider capacity including provider counts, network stability, provider-to-member ratios, and network availability and accessibility. These analytic elements, in conjunction with the DSN Narrative, inform the overall DSN Evaluation.
5	With the Federal rule, if we were to be inconsistent in how we treat telehealth vs. Federal rule in that the location of the member is where the service occurs and not the location of the telehealth provider, therefore would the telehealth provider be 0 miles from the member to be congruent?	Please see the response to Question #3.
6	We and other groups had questions/issues on the "centroid" method and the implementation of it did not have much guidance, especially on how to classify people and how to do it in Quest?	While OHA does not provide specific guidance on time and distance calculation methodologies or the use of specific geomapping software, the intent of the activity is for CCOs to assess time and distance based on the physical location of members and providers. Subcontractors should work with their respective CCOs and vendors (e.g., Quest Analytics) to ensure appropriate methodologies are used in calculation of time and distance compliance. If you have specific questions regarding the attribution of location to members or providers, please reach out to OHA and/or HSAG for technical assistance.
7	Several CCOs (YCCO included) use Quest Analytics so general guidance to CCOs on that would be helpful.	OHA does not require the use of specific software when monitoring network adequacy, so general guidance is not currently available for specific software platforms (e.g., Quest Analytics). Please reach out to OHA and HSAG with specific questions for technical assistance.

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8	Does OHA/HSAG ever calculate the ratio of credentialed interpreters on the registry to the number of members by spoken language?	No, OHA does not currently evaluate the ratio of registered interpreters to members' language needs.
9	General question about Quest Analytics: Is anyone aware of whether someone from HSAG or OHA consults with Quest about any changes in methodology? If not, I would request that this happen. Given that they provide this service for several CCOs across Oregon this would be preferable to each CCO needing to bring this up with Quest separately.	No, neither HSAG nor OHA has worked with Quest Analytics regarding the 2024 changes to network adequacy standards. Quest Analytics, while a common platform for network adequacy monitoring, is not the sole vendor for Oregon's CCOs, nor is it necessarily endorsed by OHA. Due to the contractual relationship of Quest Analytics relevant to CCOs, it is OHA's expectation that CCOs will communicate with Quest Analytics and other vendors as necessary to ensure accurate network assessment.
10	"Average drive time and distance to the nearest provider" seems to be a different measure than "which members are within acceptable time and distance to various provider tiers" like the OAR calls for. Is this Average HSAG specific requirement? The amount of calculations to achieve the average is much greater than determining a percent of acceptable member drive times and distances to providers.	The reference to "average drive time and distance to the nearest provider" is to supplemental analyses performed by HSAG to highlight the average drive time and distance to the closest first, second, and third provider to obtain additional information on the distribution of providers relative members. Compliance with the Oregon network adequacy standard is based on 95 percent of members with access to providers within acceptable travel time or distance [OAR 410-141-3515 (8)].
11	If we "met" a component last year and did not have any significant changes, do we still need to provide the two most recent sample reports of the documentation we provided in last year's submission? To clarify, say we had a met on all of 2.1 last year, and we submitted several different documents to substantiate our narrative, would we still provide each of those documents again this year, even though we have a met and have no significant changes?	If a CCO received a *Met* rating on a DSN Narrative Element in 2023, the CCO must still submit all documents that are identified as "(required)." These are typically focused on the reports, dashboards, or survey results reviewed by the CCO's network adequacy monitoring/decision-making body in support of their work. Other documentation which may have supported individual elements (e.g., survey monitoring policies and procedures) would not have to be submitted unless there was a change to those processes. CCOs should contact HSAG if any clarification is needed on what would constitute a "change" for a specific area of assessment.
12	Can I clarify two most recent reports, does this refer to the look back period, or most recent in 2024?	The *two most recent reports* prompt refers to the two most recent reports prepared as of the review period—i.e., July 1, 2023 – June 30, 2024. If a document identified as "required" is only produced annually, then the last two reports should be submitted, including a report that may fall outside the look back period.

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13	Do we need to address change in methodology from 2023-2024 in [the time and distance monitoring] section? The new standards went into effect mid reporting year making both methodologies utilized.	If a CCO received a *Met* rating in 2023 and the only change made to the CCO's policies, procedures, and processes was to account for the new time and standards, then the CCO would not address the change. However, CCOs that received a *Partially Met* or *Not Met* rating would have to address the update to methodology. Please note that the 2024 Network Adequacy Validation audit activity will assess the accuracy of the CCO's calculation and reporting of time and distance metrics.
14	In our non-Medicaid contracts, it stipulates that our DSN Network narrative is also applicable in our [Healthier Oregon Program (HOP)] population, therefore is there any guidance on how to reflect our HOP membership within the DSN Network Narrative?	The DSN Evaluation is intended to capture all network monitoring activities performed by the CCO of its OHP members, including CCO members enrolled through the Healthier Oregon expansion program. For specific questions regarding non-Medicaid contract requirements, please reach out directly to OHA.