Oregon Health Authority
Health Services Division

2019 Delivery System Network Evaluation of Oregon Coordinated Care Organizations

January 2020

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Objective/Overview

Overview

Federal and State regulations require each Medicaid managed care contractor to maintain a network of appropriate healthcare providers, to ensure adequate access to all services covered under the Medicaid contract. Each contractor must submit documentation to the State Medicaid authority demonstrating the contractor's capacity to serve enrolled members in its service area in accordance with the State's standards for access to care.[1-1]

The Oregon Health Authority (OHA) oversees Oregon's Medicaid program and contracts with 15 regional coordinated care organizations (CCOs) to deliver managed care services for Medicaid members in the State. CCOs are required to submit an annual integrated Delivery System Network (DSN) Report and analysis to OHA by July 1 every year. The DSN Report should include two components, a DSN Provider Narrative Report and a DSN Provider Capacity Report, that serve as a crosswalk of network standards and the requirements of the Medicaid contract: OHA 2019 Health Plan Services CCO Contract, Exhibit G (1)(b)(2).

OHA requested Health Services Advisory Group, Inc. (HSAG), the State's contracted external quality review organization (EQRO), provide a comprehensive review of the 2019 CCO DSN reports including findings regarding provider capacity compliance in accordance with standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN. Overall findings from the review, individual CCO results, and recommendations to the State are included in this DSN Evaluation Report.

DSN Evaluation Report Objective

Based on the requirements outlined in the OHA 2019 Health Plan Services CCO Contract, Exhibit G (1)(a)(b), HSAG developed the DSN Evaluation Report to provide OHA with an evaluation of CCO network compliance with established network standards and timely access to care and services requirements. To conduct the evaluation, HSAG reviewed:

1. Each CCO's DSN Provider Narrative Report and supplemental documentation.
2. The distribution and documentation of each CCO's inventory of providers and facilities.

[1-1] See 42 Code of Federal Regulations (CFR) §438.206 and §438.207; Oregon Administrative Rule (OAR) 410-141-3220.

DSN Provider Narrative Report

Pursuant to 42 CFR §438.206 and 42 CFR §438.207, the CCOs are required to demonstrate to OHA, with supporting documentation, that all covered services are available and accessible to members and that they have adequate provider capacity.

The DSN Provider Narrative Report requirement defines five categories based on OHA's CCO contract requirements. Each category includes corresponding elements that require the CCOs to describe how they monitor and ensure adequate provider capacity in their delivery networks. CCOs must submit written responses and supplemental documentation (where appropriate) to the OHA Contract Administration Unit via the DSN Provider Narrative Report. The reports are processed by OHA and then forwarded to HSAG for review, evaluation, and collective reporting.

If a CCO subcontracts or delegates delivery network required activities, the CCO must also describe how it conducts vendor/delegate oversight and monitoring. CCOs may elect to contract or delegate responsibility for the reporting and monitoring of adequate provider capacity, but are ultimately responsible for ensuring compliance with federal and State provider network requirements. The five categories outlined in the DSN Provider Narrative Report Categories are listed in Table 1-1 below.

Table 1-1—DSN Provider Narrative Report Categories

Category Number	Category Description	Number of Elements
1	Description of the Delivery Network and Adequacy	12
2	Description of Members	3
3	Additional Analysis of the CCO's Provider Network to Meet Member Needs	4
4	Coordination of Care	5
5	Performance on Metrics	2

DSN Provider Capacity Report

CCOs submit a DSN Provider Capacity Report, which is an inventory of the CCOs' providers and facilities, using a Provider Capacity Report Template provided by OHA. All participating providers, either employed directly or through subcontract with a CCO and providing services to Medicaid and dual-eligible members, were included. Required data elements of the report are outlined in the 2019 Health Plan Services CCO Contract, Exhibit G (1)(b)(2). Providers and facilities are categorized using Medicaid Management Information System (MMIS) provider type and specialty codes, as indicated in the 2019 Health Plan Services CCO Contract. The service categories used in the DSN Provider Capacity Report Categories are identified in Table 1-2 below.

Table 1-2—DSN Provider Capacity Report Service Categories

Provider Category	Service Category	
Individual Physicians, Mid-Level and Other Practitioners	• Certified or Qualified Health Care Interpreters • Traditional Health Workers (THWs) • Dental Service Providers • Mental Health Providers • Oral Health Providers	• Primary Care Providers (PCPs) • Specialty Practitioners • Substance Use Disorder (SUD) Providers • Other not listed but included in the CCO integrated and coordinated service delivery network
Facilities (Services)	• Hospital, Acute Psychiatric Care • Alcohol/Drug • Ambulance and Emergency Medical Transportation • Community Prevention Services • Federally Qualified Health Centers • Health Education, Health Promotion, Health Literacy • Home Health • Hospice • Hospital • Imaging • Indian Health Services (IHS) and Tribal Health Clinics	• Mental Health Crisis Services • Non-Emergent Medical Transportation (NEMT) • Palliative Care • Patient Centered Primary Care Homes (PCPCH) • Pharmacies • Durable Medical Providers • Post-Hospital Skilled Nursing Facility • Rural Health Centers • School-based Health Centers • Urgent Care Center • Other not listed but included in the CCO integrated and coordinated service delivery network

Report Review and Scoring

HSAG reviewed each CCO's DSN Provider Narrative Report, assessed each category, and evaluated the elements of each category. Elements evaluated received a score ranging from 0.0 (*Not Met*) to 1.0 (*Met*) based on the scoring criteria defined in Table 2-1 below. Element scores were then aggregated into category scores and an overall summary score.

Table 2-1—DSN Provider Narrative Report Scoring Criteria

Score	Rating	Rating Description
0.0	Not Met	Discussion does not address the element.
0.5	Partially Met	Discussion addresses some, but not all of the element.
1.0	Met	Discussion comprehensively addresses the element.

The points possible for each DSN Provider Narrative Report category are outlined in Table 2-2 below. A maximum of 26.0 total points was possible across all five categories.

Table 2-2—DSN Provider Narrative Report Categories

Category Number	Category	Number of Elements	Maximum Points
1	Description of the Delivery Network and Adequacy	12	12.0
2	Description of Members	3	3.0
3	Additional Analysis of the CCO's Provider Network to Meet Member Needs	4	4.0
4	Coordination of Care	5	5.0
5	Performance on Metrics	2	2.0
	Totals	**26**	**26.0**

Note: *Maximum points possible differs from the 2018 DSN Evaluation Report due to changes in the scoring criteria.*

Based on the submitted 2019 DSN Provider Capacity Reports, HSAG assessed the quality and completeness of each CCO's provider network. Due to the extent of CCO data and reporting inconsistencies, the DSN Provider Capacity Reports were not directly scored or aggregated; however, HSAG conducted comparative evaluations across CCOs and highlighted variations in the quality and completeness of data.

Overall DSN Provider Narrative Report Review Results

Overall, the CCOs received a score of 24.3 points across aggregated DSN Provider Narrative Report Categories, or approximately 93.5 percent of the maximum points possible (26.0 points), as shown in Table 3-1 below. Three of the 15 CCOs met the requirements of all DSN Provider Narrative Report Categories. While most CCOs met the *Coordination of Care* and *Performance on Metrics* categories, only three CCOs met the *Description of the Delivery Network and Adequacy* narrative category and one CCO struggled to meet narrative categories across the board. As such, while CCO overall aggregate performance was fair, the variation in scores among the CCOs indicated several opportunities for improvement.

Table 3-1—DSN Provider Narrative Report Review Results

CCO Name*	DSN Provider Narrative Report Categories					Total CCO Score
	Description of the Delivery Network and Adequacy	Description of Members	Additional Analysis of the CCO's Provider Network to Meet Member Needs	Coordination of Care	Performance on Metrics	
AH	12.0	3.0	4.0	5.0	2.0	26.0
AllCare	8.0	1.5	3.0	5.0	2.0	19.5
CHA	12.0	3.0	4.0	5.0	2.0	26.0
CPCCO	11.5	3.0	4.0	5.0	2.0	25.5
EOCCO	11.0	3.0	4.0	5.0	2.0	25.0
HSO	12.0	3.0	4.0	5.0	2.0	26.0
IHN CCO	8.0	2.5	3.5	3.0	2.0	19.0
JCC	11.5	3.0	3.5	5.0	2.0	25.0
PSCS-CO	11.0	2.5	3.0	5.0	2.0	23.5
PSCS-CG	11.0	2.5	3.0	5.0	2.0	23.5
PH	12.0	3.0	4.0	4.0	2.0	25.0
TCHP	11.5	3.0	4.0	5.0	2.0	25.5
UHA	12.0	2.5	4.0	5.0	2.0	25.5
WVCH	12.0	2.5	4.0	5.0	2.0	25.5
YCCO	10.0	3.0	4.0	5.0	2.0	24.0
Statewide Average Scores	**11.0**	**2.7**	**3.7**	**4.8**	**2.0**	**24.3**
Points Possible	**12.0**	**3.0**	**4.0**	**5.0**	**2.0**	**26.0**

* Please see Appendix B for a list of full CCO names.

Description of the Delivery Network and Adequacy

The *Description of the Delivery Network and Adequacy* category contained elements that pertained to the geographic distribution of the CCO's providers relative to the geographic distribution of its membership as well as the CCO's ability to meet time and distance standards in addition to member-to-provider ratios for primary care, specialty (e.g., pediatric, adult, and geriatric), behavioral health, and dental care providers, among other providers. This category also required each CCO to define its method of geocoding and analysis. Additional elements that the CCOs had to address included membership access to NEMT, transportation and access for members with disabilities or special health care needs (SHCN), demonstration of the continuum of care for treatment of mental health disorders and treatment of SUDs, and a description of network availability/adequacy and use of alternative therapies to meet the needs of members.

CCO Results

Six of the 15 CCOs met all of the elements in the *Description of the Delivery Network and Adequacy* narrative category.

The majority of the CCOs' narrative responses were limited in describing, demonstrating, and analyzing the delivery network and their adequacy of member access to healthcare services, resulting in CCOs scoring the lowest across the possible amount of points in this category compared to the other categories.

While not all of the CCOs provided the required geographic distribution description and analysis for all providers (including delegated providers), seven CCOs specifically described the use of geocoding software to analyze the geographic distribution of providers relative to members, including member access to specialists in alignment with time and distance standards; however, there were inconsistencies with CCO descriptions of the methodologies used to calculate those standards. Four of the 15 CCOs calculated time and distance standards by using a member and provider's address ZIP Code or "central point," instead of the precise locations of both groups. Measuring with ZIP Codes or "central point" of members to the closest provider within the same ZIP Code or "central point" produces an inaccurate estimate of the routine travel time and distance.

The majority of CCO narratives provided descriptions of member to provider ratios for PCPs, specialists, mental health practitioners, SUD treatment providers, dental care providers, and availability of acute care beds. However, four of the 15 CCOs described behavioral health providers ratios instead of stratifying the ratio by members to mental health and SUD treatment providers. In addition, these four CCOs did not address ratios of members to providers that specifically render care to adult, pediatric, and geriatric memberships.

All 15 narrative responses described how the CCOs ensure the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day, 7 days a week for all members. For example, one CCO described the different relationships it and its delegated organizations have to ensure on-call access; same-day and walk-in appointments; and crisis services with physical, dental, and mental health providers. The CCO financially underwrote a Mobile Youth Crisis Response Unit (MY CRU) in one of

its service area counties to respond to child and adolescent psychiatric emergencies, reducing the need for care through the emergency department.

Conclusions

Drawing on the narrative responses, HSAG concluded that the CCOs need to integrate OHA network adequacy contractual requirements and analyses into their ongoing monitoring activities to ensure member access to covered services within their delivery network system. This monitoring process may require additional technical assistance on mechanisms to capture complete and accurate provider data and report on delivery system network adequacy. In addition, CCOs should conduct more comprehensive time and distance analyses, ensuring that each member's routine time and distance to a participating provider's location does not exceed the OHA standard for accessing care from providers within the delivery network. Standardization of reporting by all CCOs would further support both the CCOs' and OHA's oversight of delivery system networks, as described in OAR 410-141-3220.

Recommendations

Based on the conclusions presented above, HSAG upholds two of the three recommendations from the 2018 DSN Evaluation Report and included one new recommendation:

- CCOs should continue designing and implementing ongoing monitoring strategies to track and evaluate members' access to care, including compliance with time and distance standards.
- CCOs should continue developing and implementing standard categorization of providers based on the member populations served by the CCOs and use those provider categories to evaluate member-to-provider ratios for key provider types including primary care, specialty (e.g., pediatric, adult, and geriatric), behavioral health, and dental providers.
- CCOs should design and implement strategies to measure routine time and distance standards from the member's precise address to the precise location of the closest participating provider; ensuring that at least 90 percent of the membership can access healthcare within each CCO's delivery system network.

Description of Members

The *Description of Members* category contained elements that required each CCO to describe its ability to identify and analyze the needs of its members. More specifically, each CCO was required to demonstrate its ability to identify and analyze the cultural, language, disability, and SHCN of its membership and use this information to assign members to appropriate providers. Additionally, CCOs were required to conduct an analysis of the distribution of specialists based on prevalence of disease to ensure member access to relevant providers, continuity of care, and appropriate transitions between different levels of care.

CCO Results

Nine of the 15 CCOs met all the elements in the *Description of Members* narrative category.

Eleven of 15 CCOs described processes for taking into account member characteristics when making provider assignments. These CCOs also included analysis demonstrating mechanisms for how the needs related to disabilities, SHCN, and language and cultural are identified for the purpose of ensuring that the assigned PCP can best address each member's needs. Two of the 15 CCOs described different available tools used to identify member characteristics and needs; however, no analysis of member needs was incorporated in the narrative responses. One CCO described not using member characteristics when making provider assignments at this time; however, interpretative services are available to meet the language needs of its membership.

The majority of CCOs described using specialized reports and multiple data sources to identify trends in disease prevalence across membership. For example, one of the CCOs described internal reports that classify the prevalence of chronic conditions among its members. The CCO also used utilization and grievance and appeals data for additional analysis of current and/or prospective deficiencies, impacting network adequacy to specialty providers. If deficiencies were identified, the CCO described its medical director working with the Provider Network department to implement a plan of action to expand network capacity.

With regard to ensuring that member needs are assessed for continuity of care and transition between levels of care, a majority of CCOs described conducting a needs assessment to identify risks and/or determine each member's appropriate level of care at the time of the transition. CCOs used assessment results to generate an individualized care plan, ensuring safe transitions and care appropriate to the member's needs. CCOs using this mechanism also described taking an interdisciplinary approach to sharing information and coordinating care with partnering hospitals, skilled nursing facilities, physicians/specialists, NEMT providers, and other community stakeholders to ensure that members receive the correct level of care and follow-up in the most appropriate setting.

Conclusions

Evaluation results indicated that the CCOs should conduct more comprehensive analyses of the cultural, language, disability, special healthcare, and diagnosis-related needs of members when assessing the adequacy of networks. The lack of consistent and complete provider data and supplemental documentation, including narrative responses that did not include the required analysis as part of the CCO's submission, made it difficult to assess and compare performance across CCOs.

Recommendations

Based on the conclusions presented above, HSAG upholds two of the three recommendations from the 2018 DSN Evaluation Report that the CCOs:

- Continue developing and implementing processes to ensure the collection of supplemental member data (e.g., cultural, language, disability, special healthcare, and diagnosis-related needs) to support the monitoring and reporting of member needs.
- Continue developing reports and internal metrics for assessing the adequacy of the CCOs' delivery system networks relative to key member characteristics.

Additional Analysis of the CCO's Provider Network to Meet Member Needs

The *Additional Analysis of the CCO's Provider Network to Meet Member Needs* category contained elements for which the CCOs described their process for incorporating member feedback (including complaints and grievances, mental health and member survey results, provider encounters, and community advisory council (CAC) input) into network adequacy decisions. In addition, CCOs were required to describe technology's role in delivery of care; procedures used to promote self-care for members with specific health care needs; and how the CCOs operationalized their commitment to making culturally and linguistically appropriate services available to members within the organization, including CCO leadership.

CCO Results

Overall, 10 of the 15 CCOs met all of the elements in the *Additional Analysis of the CCO's Provider Network to Meet Member Needs* narrative category.

Five of the 15 CCOs did not meet the first element of this category that required CCOs to incorporate member feedback into network adequacy decisions. Three of the five CCOs provided narratives that reported they had established CAC and described how input from the councils was used to support and influence network adequacy and/or network capacity; however, the CCOs did not address how they incorporated member feedback obtained from mental health surveys, complaints and grievances, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3-2] survey results. Two CCOs described analyzing member feedback and input from both sources but did not report how it incorporates and uses the information in network adequacy decisions. In order to effectively monitor network adequacy and to identify issues with network capacity, timely access to care, and provider-specific deficiencies, CCOs should have mechanisms to collect and use member and community feedback.

Twelve of the 15 CCOs reported mechanisms to ensure that members with specific healthcare needs receive follow-up and training in self-care and other interventions. For example, one CCO described and provided several examples of programs available to promote member self-care with specific healthcare needs. This CCO also described a program in partnership with a local elementary school to reduce and prevent childhood obesity that includes physical activities, mindfulness practices, nutrition education, growing a garden, and healthy cooking.

[3-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Conclusions

Drawing on the narrative responses, HSAG concluded that the CCOs were not making concerted efforts to incorporate member feedback when making network decisions and assessing adequacy. Evaluation results indicated that CCOs were not able to obtain and analyze feedback from member-focused surveys (i.e., mental health surveys [i.e., adult (Mental Health Statistics Improvement Program [MHSIP] survey), family (Youth Services Survey for Families [YSS-F]), and child (Youth Services Survey [YSS])] and CAHPS surveys) and use the results to guide network adequacy decisions. Additionally, although CCOs regularly convene CAC as required by Oregon Revised Statute (ORS) 414.627, feedback from council meetings is also not being incorporated into network adequacy decisions.

Recommendations

Based on the conclusions presented above, HSAG upholds the three recommendations from the 2018 DSN Evaluation Report that the CCOs:

- Continue developing mechanisms to collect member feedback from existing data sources (e.g., member and healthcare surveys, complaints and grievances, CAC, etc.) and incorporate the information into network adequacy analyses in order to support network management decisions.
- Continue developing and implementing new mechanisms (e.g., surveys, stakeholder meetings, member forums, etc.) to collect information on member feedback.
- Continue improving the quality of information reported in the CCO narratives to better demonstrate how the CCOs use member feedback in making network decisions and assessing network adequacy.

Coordination of Care

The *Coordination of Care* category contained elements that required the CCOs to describe their relationships and ability to coordinate care with community agencies and stakeholders. In addition, CCOs were required to describe the use of interdisciplinary teams and electronic health records (EHRs) to identify and assess members with SHCN and coordinate services across the continuum of care to reduce hospital readmission, emergency room use, and access to preventive healthcare.

CCO Results

Thirteen of the 15 CCOs met all of the elements in the *Coordination of Care* narrative category.

The majority of CCOs described how interdisciplinary care teams and coordination supports are used across each member's continuum of care. The CCO narrative responses demonstrated a more integrated approach across the spectrum of physical, mental, and dental healthcare than the previous year. For example, one CCO described its established regional care teams that serve as a single point of contact for members, providers, community agencies, and other stakeholders to receive assistance navigating the physical, dental, and mental health delivery networks and social support service systems. The CCO also described its care team staff members as having a diverse level of expertise and knowledge in care plan

development, transitions of care, coordinating SHCN or complex needs, and case management across the continuum of care.

The CCOs submitted narrative responses with thorough descriptions and, in some instances, supporting documentation, to demonstrate all of the elements in this category. All CCOs described how internal and external platforms of EHRs are used to coordinate healthcare, including preventive healthcare, for all members across the continuum of care. Several CCOs described the use of Pre-Manage, a medical platform tool, to share real-time hospital/emergency department event information; member-level data and preventive gaps in care; and member-specific information for the purpose of coordinating physical, dental, and mental healthcare between provider offices, hospitals, and community partners.

All CCOs had some mechanism for assessing and identifying SHCN, including but not limited to, the physical, dental, and mental health of its membership. Several CCO narratives described completing health risk assessments (HRAs) for newly enrolled members and/or those members transitioning between different levels of care, ensuring members receive the appropriate care across their continuum of care. In addition, many CCOs described identifying SHCN using OHA's 834 eligibility file, internal data systems, utilization reporting, medical record review, community agencies/partners, referrals for case management services, and community case managers. For example, one CCO described using an innovative platform that incorporates claims data, diagnosis, PCP referral information, pharmacy data, Program Eligibility Resource Code (PERC), and rate codes. The platform is designed to assess members, stratify them into healthcare profiles, identify member needs, and coordinate care.

Conclusions

Evaluation results indicated that each CCO has established relationships with local Aging and Persons with Disabilities offices, public health authorities, and mental health authorities that facilitate the coordination of member services across the continuum of care. Overall, the CCO responses demonstrated that their interdisciplinary care team's care coordination activities are more integrated and inclusive of physical, mental, and dental health services, facilitating various types of care coordination based on a member's SHCN, level of complexity, and location.

Recommendations

Based on the conclusions presented above, HSAG upholds two of the three recommendations from the 2018 DSN Evaluation Report that the CCOs:

- Continue expansion of internal processes and operational mechanisms to facilitate a care coordination approach that integrates physical health, mental health, and dental health services and supports.
- Continue integrating EHR reporting and feedback from interdisciplinary care teams and community stakeholders to improve care coordination services and support the integration of all member healthcare needs, especially for members with SHCN.

Performance on Metrics

The *Performance on Metrics* category contained elements related to the CCOs' efforts to build network capacity for those quality metrics that performed below established baseline rates. Additionally, the CCOs were required to describe how they analyze patterns of underutilization and overutilization along with the actions they took to address the underutilization or overutilization of services.

CCO Results

All of the 15 CCOs met all of the elements in the *Performance on Metrics* narrative category.

The CCO narratives described regular internal monitoring of performance metrics through oversight committees whose objectives included improving performance measure rates by creating action plans, executing both provider and member quality improvement initiatives, and implementing changes to the delivery network. A majority of CCOs described furnishing actionable reports to providers and/or individual offices in an effort to improve performance on metrics related to member access and emergency department utilization. One CCO reported conducting a regular evaluation of its delivery system network to determine if inadequate provider performance is related to network capacity and/or lack of access. The CCO also established an access to care team for a cross-functional approach to reviewing and supporting providers with CCO-identified initiatives related to improving member access to care and provider performance on metrics.

The majority of the CCOs described a methodology for analyzing and monitoring underutilization and overutilization, including using claims data and other analytic tools. CCO narratives described implementing workgroups that included community partners, provider-specific corrective action plans, alternative payment models, disease-specific case management programs, and member education as some of the actions taken to address patterns of both overutilization and underutilization. For example, one CCO described how its Quality and Clinical Advisory Panel (QCAP) reviews and discusses underutilization and overutilization data. When trends are identified, the panel makes suggestions and operationalizes an appropriate plan of action.

Conclusions

Overall, the CCOs described their processes for monitoring performance metrics internally and across their delivery system network. CCO narrative responses addressed mechanisms for tracking and analyzing overutilization and underutilization. Two CCOs submitted their policies and procedures to demonstrate how overutilization and underutilization are monitored, detected, and addressed. All CCOs should develop and implement written procedures that define the frequency of reporting and monitoring of overutilization and underutilization patterns and processes for addressing them.

Recommendations

Based on the conclusions presented above, HSAG upholds the two recommendations from the 2018 DSN Evaluation Report that the CCOs:

- Continue internal monitoring of CCO performance on quality measures and implement appropriate changes to its delivery network to support measure improvement.
- Continue to track and analyze overutilization and underutilization patterns and develop mechanisms to address and correct identified patterns.

Gaps in Time and Distance Standards Reporting

As part of the DSN Provider Narrative Report, the CCOs were required to demonstrate to OHA that their provider capacity also met time and distance standards. HSAG reviewed and assessed each CCO's time and distance reporting for each service category and the corresponding geographic classification.

CCO Results

Eleven of 15 CCOs met all of the elements in the *Time and Distance* narrative section. The CCOs reported their access standards compliance in either routine time or distance (i.e., minutes and miles) or with the percentage of members in the service area that can access healthcare from the network. Compliance with the standard was demonstrated as:

- In urban areas, not exceeding 30 miles, 30 minutes.
- In rural areas, not exceeding 60 miles, 60 minutes.
- A minimum of 90 percent of members in each service area accessing care within the respective routine travel time or distance listed above.

Two of the 15 CCOs did not provide time and distance standards in minutes, miles, or percentages. One of the CCOs referenced a Network Adequacy Sample Report in the "Description of the Delivery Network and Adequacy" section; however, the referenced sample was not included as part of the CCO's submission. The other CCO submitted a Network Adequacy Sample Report; however, it was specific to calculating distance from Medicare beneficiaries to market providers. In addition, the document noted "0 gaps," but did not include logic or a report description as it relates to the content of the graphic.

Three of the 15 CCOs self-identified their service area as either only rural or only urban, resulting in an "N/A" for the corresponding geographic classification in which the CCO does not render services. Eight of the 15 CCOs reported standards for both classifications of geographic service areas. Two of the 15 CCOs reported across both urban and rural geographic distinctions but did not provide results for all of the OHA-identified service categories.

Conclusions

Evaluation results indicated various methods used by CCOs to calculate and report time and distance standards, restricting HSAG's ability to develop an aggregated analysis of provider capacity across CCOs. CCOs should conduct more comprehensive time and distance analyses, ensuring that each member's routine time and distance to a participating provider's location does not exceed the OHA standard for accessing care from providers within the delivery network. Standardization of reporting by all CCOs would further support both the CCOs' and OHA's oversight of delivery system networks.

Recommendations

Based on the conclusions presented above, HSAG upholds two of the three recommendations from the 2018 DSN Evaluation Report and included one new recommendation:

- CCOs should continue developing and implementing reporting mechanisms for assessing each member's routine travel time and distance to participating providers (e.g., PCP, PCPCH, Obstetrics/Gynecology [OB/GYN], Mental Health/Behavioral Health [MH/BH], Behavioral Health/Substance Use Disorder [BH/SUD], Hospital, Pharmacy, Dental, and Specialist) within the CCOs' delivery system network, ensuring compliance with the OHA standard.
- CCOs should continue developing and implementing standard categorization of providers based on the member populations (e.g., adult and pediatric) served by the CCOs and use those service categories to evaluate time and distance that includes primary care, specialty behavioral and mental health, mental health/SUD, and dental providers.).
- CCOs should ensure that the routine time and distance standard is measured from each member's precise address to the precise location of the closest participating provider, ensuring that at least 90 percent of the membership can access healthcare within the CCO's delivery system network.

For Table 3-2, HSAG inserted an "X" to indicate an element was included in the respective CCO's DSN Provider Narrative Report. A yellow highlighted "O" indicates the element was omitted from the respective CCO's DSN Provider Narrative Report. An "N/A" indicates geographic service areas (e.g., rural or urban) in which the CCO does not operate and are, therefore, not applicable.

Table 3-2—DSN Provider Narrative Report Review Results—Time and Distance

DSN Provider Narrative Report Review Results—Time and Distance																
Service Category	**Geographic Classification**	**AH**	**ALL CARE**	**CHA**	**CPCCO**	**EOCCO**	**HSO**	**IHN CCO**	**JCC**	**PSCS-CO**	**PSCS-CG**	**PH**	**TCHP**	**UHA**	**WVCH**	**YCCO**
PCP-Adult	Urban-Time	N/A	X	N/A	O	X	X	X	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	X	O	X	X	X	X	X	X	X
	Rural-Time	X	X	X	O	X	N/A	X	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	X	O	X	X	X	X	X	X	X
PCP-Peds	Urban-Time	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Rural-Time	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
PCPCH	Urban-Time	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Rural-Time	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
OB/GYN	Urban-Time	N/A	O	N/A	O	X	X	X	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	X	O	X	X	X	X	X	X	X
	Rural-Time	X	O	X	O	X	N/A	X	O	X	X	X	X	X	X	X
	Rural-Distance	X	O	X	O	X	N/A	X	O	X	X	X	X	X	X	X
MH/BH-Adult	Urban-Time	N/A	O	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Rural-Time	X	O	X	O	X	N/A	O	O	X	X	X	X	X	X	X

DSN Provider Narrative Report Review Results—Time and Distance																
Service Category	**Geographic Classification**	**AH**	**ALL CARE**	**CHA**	**CPCCO**	**EOCCO**	**HSO**	**IHN CCO**	**JCC**	**PSCS-CO**	**PSCS-CG**	**PH**	**TCHP**	**UHA**	**WVCH**	**YCCO**
	Rural-Distance	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
MH/BH-Peds	Urban-Time	N/A	O	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Rural-Time	X	O	X	O	X	N/A	O	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
BH/SUD-Adult	Urban-Time	N/A	O	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Rural-Time	X	O	X	O	X	N/A	O	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
BH/SUD-Peds	Urban-Time	N/A	O	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Rural-Time	X	O	X	O	X	N/A	O	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
Hospital	Urban-Time	N/A	O	N/A	O	X	X	X	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	X	O	X	X	X	X	X	X	X
	Rural-Time	X	O	X	O	X	N/A	X	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	X	O	X	X	X	X	X	X	X
Pharmacy	Urban-Time	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Rural-Time	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X

DSN Provider Narrative Report Review Results—Time and Distance																
Service Category	**Geographic Classification**	**AH**	**ALL CARE**	**CHA**	**CPCCO**	**EOCCO**	**HSO**	**IHN CCO**	**JCC**	**PSCS-CO**	**PSCS-CG**	**PH**	**TCHP**	**UHA**	**WVCH**	**YCCO**
Dental-Adult	Urban-Time	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Rural-Time	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
Dental-Peds	Urban-Time	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Rural-Time	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
Specialist-Adult	Urban-Time	N/A	X	N/A	O	X	X	X	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	X	O	X	X	X	X	X	X	X
	Rural-Time	X	X	X	O	X	N/A	X	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	X	O	X	X	X	X	X	X	X
Specialist-Peds	Urban-Time	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Urban-Distance	N/A	X	N/A	O	X	X	O	O	X	X	X	X	X	X	X
	Rural-Time	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X
	Rural-Distance	X	X	X	O	X	N/A	O	O	X	X	X	X	X	X	X

Overall DSN Provider Capacity Report Review Results

Annually, OHA requires all CCOs to submit the DSN Provider Capacity Reports. The DSN Provider Capacity Reports provide an inventory of providers and facilities within the CCOs' provider networks. HSAG's evaluation of the 2019 DSN Capacity Reports was compiled into two DSN Provider Capacity Report Review Results tables: (1) Service Categories and (2) Data Fields. HSAG conducted a comparison of the data that resulted in the following key observations.

- Of the 15 CCOs, 11 CCOs submitted a DSN Provider Capacity Report using the required template available on OHA's website. Of the remaining four, two CCOs submitted separate reports for different provider types. For example, one CCO submitted six different report tabs (e.g., one physical health, one mental health, three dental health, and one transportation) corresponding to different service categories while another CCOs submitted capacity reports separated by physical health and facility. Three of the remaining four CCOs also provided written descriptions to identify different provider types.
- Of the 15 CCOs, 14 CCOs submitted all of the required provider data fields of the DSN Provider Capacity Report. The remaining CCO submitted six different report tabs (one physical health, one mental health, three dental health, and one transportation) corresponding to different service categories. The mental health providers tab did not accurately identify the required provider type and specialty codes. Instead, the CCO included the providers' credentials in the provider type codes data field and combined both required codes in the specialty code data field.
- None of the CCOs submitted a DSN Provider Capacity Report format that included all 30 of the required categories of service. Seven of the categories of service listed in the DSN Provider Capacity Report—Service Categories table did not have associated MMIS-identified provider type or specialty type codes. The seven categories of service were validated with the use of keyword searches (i.e., "interpreters," "education," "prevention services," "crisis," "urgent care," etc.), resulting in three (i.e., Community Prevention Services; Health Education, Health Promotion, Health Literacy; and Mental Health Crisis Services) of the seven categories of service not being validated in any of the CCOs' reports. Three of the 15 CCOs provided written descriptions to identify the categories of service that did not have assigned MMIS provider and/or specialty types, resulting in all 30 categories of service being accounted for. Another CCO submitted a written description, identifying for two of the seven service categories that did not have an MMIS code.
- All 15 CCOs submitted DSN Provider Capacity Reports in which 13 of the 30 categories of service were validated.
- Each CCO included additional categories of service in its DSN Provider Capacity Report that were not in the original list but are part of the CCO's integrated and coordinated delivery system network. For example, categories of service such as Chiropractor, Acupuncturist, Registered Dietician, End Stage Renal Disease (ESRD) Clinic, and Freestanding Birthing Center were identified as "Others not listed but included in the CCO's integrated and coordinated DSN."

Table 3-3 and Table 3-4 include the CCO DSN Provider Capacity Report Review Results for Service Categories and Data Fields Elements. For each table, HSAG inserted an "X" to indicate an element was included in the respective CCO's DSN Provider Capacity Report. A yellow highlighted "O" indicates the element was omitted from the respective CCO's DSN Provider Capacity Report.

Table 3-3—DSN Provider Capacity Report Review Results—Service Categories

DSN Provider Capacity Report Review Results—Service Categories															
Service Category	**AH**	**ALL CARE**	**CHA**	**CPCCO**	**EOCCO**	**HSO**	**IHN CCO**	**JCC**	**PSCS-CO**	**PSCS-CG**	**PH**	**TCHP**	**UHA**	**WVCH**	**YCCO**
Hospital, Acute Psychiatric Care	O	O	O	X	O	X	O	O	O	O	O	O	X	O	X
Alcohol/Drug	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Ambulance and Emergency Medical Transportation	X	X	X	X	X	X	X	X	X	X	O	X	X	O	O
Certified or Qualified Health Care Interpreters	X	O	O	X	O	X	O	O	O	O	O	X	X	X	O
Community Prevention Services	O	O	O	X	O	X	O	O	O	O	O	O	X	O	O
Dental Services Providers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Federally Qualified Health Centers	X	X	O	X	X	X	X	X	X	X	X	X	X	X	X
Health Education, Health Promotion, Health Literacy	O	O	O	X	O	X	O	O	O	O	O	O	X	O	O
Home Health	X	X	X	X	X	X	X	X	X	X	O	X	X	X	X
Hospice	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hospital	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Imaging	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
IHS and/or Tribal Health Clinic	X	X	X	X	X	X	O	X	O	O	X	X	X	X	O
Mental Health Providers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mental Health Crisis Services	O	O	O	X	O	X	O	O	O	O	O	O	X	O	O
NEMT	X	X	X	X	X	X	X	X	X	X	O	X	X	X	O
Oral Health Providers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Palliative Care	O	X	X	X	X	X	X	X	O	O	O	O	X	X	O
PCPCHs	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

DSN Provider Capacity Report Review Results—Service Categories															
Service Category	**AH**	**ALL CARE**	**CHA**	**CPCCO**	**EOCCO**	**HSO**	**IHN CCO**	**JCC**	**PSCS-CO**	**PSCS-CG**	**PH**	**TCHP**	**UHA**	**WVCH**	**YCCO**
Pharmacies	X	X	X	X	X	X	X	X	X	X	X	X	X	X	O
Durable Medical Providers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Post-Hospital Skilled Nursing Facility	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PCPs	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Rural Health Centers	X	O	O	X	X	X	X	X	X	X	X	X	X	O	O
School-based Health Centers	X	O	O	X	X	X	O	X	X	X	X	O	X	O	X
Specialty Practitioners	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Substance Use Disorder Providers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Traditional Health Workers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	O
Urgent Care Center	O	X	O	X	X	X	X	O	X	X	X	X	X	X	X
Others not listed but included in the CCO's integrated and coordinated DSN	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Table 3-4—DSN Provider Capacity Report Review Results—Data Fields

DSN Provider Capacity Report Review Results—Data Fields															
Required Provider Data Fields	**AH**	**ALL CARE**	**CHA**	**CPCCO**	**EOCCO**	**HSO**	**IHN CCO**	**JCC**	**PSCS-CO**	**PSCS-CG**	**PH**	**TCHP**	**UHA**	**WVCH**	**YCCO**
Last Name of Physician or Mid-Level Practitioner	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
First Name of Physician or Mid-Level Practitioner	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Individual Provider Type Code	X	X	X	X	X	X	X	X	X	X	X	X	X	O	X
Individual Provider Specialty Type Code	X	X	X	X	X	X	X	X	X	X	X	X	X	O	X
Provider National Provider Identifier (NPI #)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Division of Medical Assistance—Oregon Medicaid Provider ID (DMAP #)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Credentialing Date	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Non-English Language Spoken	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Facility Name	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Address	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
City	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ZIP Code	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
County	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Phone	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Business (Facility) Type Code	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Business (Facility) Specialty Code	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

DSN Provider Capacity Report Review Results—Data Fields															
Required Provider Data Fields	**AH**	**ALL CARE**	**CHA**	**CPCCO**	**EOCCO**	**HSO**	**IHN CCO**	**JCC**	**PSCS-CO**	**PSCS-CG**	**PH**	**TCHP**	**UHA**	**WVCH**	**YCCO**
Business Facility) NPI #	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PCPCH Tier	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Number of Members Assigned to PCP (PCPCH Providers Only)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Open to New Members	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
In-Network, Out-of-Area	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

4. DSN Reporting Recommendations

DSN Provider Narrative Report Recommendations

The DSN Provider Narrative Report is intended to ensure provider compliance with network adequacy standards established in accordance with paragraphs (b)(1) and (2) of 42 CFR §438.206 and the OHA 2019 Health Plan Services CCO Contract, Exhibit G (1)(a)(b). While OHA provided a DSN Provider Narrative Report Template for the CCOs to use, the required template provided minimal instruction and elements in the template differed from the network adequacy questions in the contract. As a result, the CCO narrative responses included varying levels of description, detail, evaluation, analysis, and reporting.

HSAG upholds all of the 2018 DSN Evaluation Report recommendations that OHA make adjustments to the required DSN Provider Narrative Report Template to minimize inconsistent interpretations of the elements and ambiguity around the appropriate type of supplemental documentation. Below are several recommendations based on identified opportunities for improvement to support enhancements to the monitoring, assessment, and reporting of network adequacy to OHA.

- **Align Category Elements with Requirements:** OHA should reevaluate the elements within the categories outlined in the DSN Provider Narrative template to ensure alignment with both the network adequacy standards established in accordance with paragraphs (b)(1) and (2) of 42 CFR §438.206 and the OHA 2019 Health Plan Services CCO Contract, Exhibit G (1)(a)(b), creating clear and concise elements that describe what is required of the CCO.
- **Identify Elements that Require Specific Responses:** OHA should redesign the DSN Provider Narrative Template to clearly define the template elements that require a CCO's responses to specify outcomes by physical health, dental health, and mental health services.
- **Include Proper Citations:** OHA should review and cite the correct contract language and/or federal regulations for each element instead of generic language.
- **Indicate when Supporting Documentation is Necessary:** OHA should identify within each category when supporting documentation is required to demonstrate compliance with reporting template elements. Instructions should include information such as what type of evidence is acceptable—e.g., report, policy and procedure, desktop process, illustration, graph, etc.
- **Establish Standardize Time and Distance Standards:** OHA should reevaluate the time and distance standard elements outlined in the DSN Provider Narrative template to ensure alignment with both the routine travel time and distance standards established in accordance with paragraphs (b)(1) and (2) of 42 CFR §438.206 and the OHA 2019 Health Plan Services CCO Contract, Exhibit G (1)(a)(b), creating clear and concise elements that describe what is required of the CCO.
- **Include Proper Instructions:** OHA should develop and implement standardized and clear instructions with detailed guidance on the appropriate method for submitting time and distance standard reporting. Instructions should also define time and distance standard measurement (e.g., minutes, miles, or percentages), geographic classification (e.g., urban, rural, etc.), and member population (e.g., adult, pediatric, etc.).

DSN Provider Capacity Report Recommendations

Reporting inconsistencies were identified among the different CCO Provider Capacity Report submissions. The current DSN Provider Capacity Report Template presents several limitations and challenges for submitting provider capacity information and for conducting analyses of statewide provider and facility inventories and comparisons across CCOs.

HSAG upholds the 2018 DSN Provider Capacity Report recommendations that OHA consider revisions to the DSN Provider Capacity Report Template and to improve the accuracy of network capacity data submitted to the State. CCO adherence to clearer guidelines will result in the submission of more consistent and accurate provider and facility inventories. Listed below are several recommendations for OHA to support more meaningful reporting of CCO provider network capacity.

- **Expand the Service Category List:** OHA should reevaluate the list of service categories included in the provider capacity report and include specific primary care and specialty care provider types to better assess whether adult, geriatric, and pediatric members have access to all covered services throughout the continuum of care.
- **Utilize the Standardized Healthcare Provider Taxonomy Code Set:** OHA should implement a time-limited work group to facilitate the adoption of the Healthcare Provider Taxonomy Code Set and eliminate the use of historical OHA MMIS provider type and specialty type codes. The Taxonomy Code Sets are a Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard code set designed to categorize the type, classification, and/or specialization of healthcare providers and facilities. All physicians and facilities are required to select the taxonomy code(s) that most closely describes the healthcare provider's type/classification/specialization when applying for a NPI).
- **Establish a Standardized Provider File Layout (PFL) with Instruction Manual:** OHA should develop and implement a standardized PFL, accompanied by a Provider Network Data Submission Instruction Manual, which would establish a more standardized data reporting structure for the CCO's submission of provider network data. The instruction manual should include detailed guidance on proper completion of the PFL, standard naming conventions, a data dictionary that categorizes provider types (i.e., primary care, physician specialty, mental health, and dental healthcare providers), program-specific definitions, standardized provider and facility type specifications, and a sample PFL template.
- **Conduct CCO Training on Proper DSN Provider Capacity Reporting:** OHA should conduct training for all CCOs and provide detailed guidance on appropriate methods for submitting provider capacity information and review the requirements for submitting provider capacity network data.
- **Establish Compliance Expectations:** OHA should hold the CCOs accountable for timely, accurate, and complete data submissions. A CCO that submits documentation that does not conform to the new templates and submission requirements within an established time frame would be rejected until the CCO's data submission adheres to the template requirements.
- **Eliminate "Mental Health Crisis Services" from the DSN Provider Capacity Report:** OHA should reevaluate the inclusion of "Mental Health Crisis Services" as one of the service categories

due to the inability of this service to be measured by capacity. Instead, adequate access to these services should be evaluated, analyzed, and described within the DSN Provider Narrative Report.

- **Expand the DSN Provider Capacity Report for Broader Use:** OHA should revise the standardized DSN Provider Capacity Report Template to be used by OHA for other provider-related reporting and ad hoc analysis (e.g., cross referencing provider types across CCOs).

Appendix A. DSN Provider Narrative Report Review Results by CCO

Advanced Health

Advanced Health (AH) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Coos and Curry counties.

AH submitted a DSN Provider Capacity Report that included all of the required data fields; however, six of the 30 OHA predetermined categories of service—one of which was Hospital, Acute Psychiatric Care—were excluded. The other five missing categories of service mirrored those that did not have an assigned MMIS provider and/or specialty type.

The CCO submitted a thorough DSN Provider Narrative Report with detailed responses, accompanied with analytics. AH described its monitoring mechanisms to ensure the provisions of appropriate urgent, emergency, crisis, and triage services 24 hours a day, 7 days a week for all members. In addition to analyzing its grievance and complaint logs and member surveys, the CCO described the different relationships it and its delegated organizations have to ensure on-call access; same-day and walk-in appointments; and crisis services with physical, dental, and mental health providers. For example, AH financially underwrote a Mobile Youth Crisis Response Unit (MY CRU) in Coos County to respond to child and adolescent psychiatric emergencies, reducing the need for care through the emergency department.

The CCO described multiple ways it incorporates member feedback from CAHPS surveys, health surveys, grievances and complaints, and its CAC into its network adequacy decision making. For instance, AH partnered with Coos Health and Wellness to purchase, acquire the necessary clearance, and place emergency contact call boxes along the North Bend Bridge in Coos County. The boxes put individuals directly in contact with a suicide prevention expert.

Table A-1 includes the complete AH DSN Provider Narrative Report review results.

Table A-1—Advanced Health—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	Met
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	1	Met
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met

Indicator		Score	Findings/Recommendations
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met
	Total Score	**10.5**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**3.0**	**Out of Possible 3.0**

Indicator		Score	Findings/Recommendations
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	1	Met
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**4.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met
21.	CCO discusses coordination with above stakeholders.	1	Met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met

Indicator		Score	Findings/Recommendations
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

AllCare CCO, Inc.

AllCare CCO, LLC (AllCare) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Curry and Jackson counties.

AllCare submitted a detailed DSN Provider Capacity Report that included all of the required data fields; however, seven of the 30 OHA predetermined categories of service were excluded. Hospital, Acute Psychiatric Care; Rural Health Centers; and School-based Health Centers were a few of the excluded services. Four of the missing categories of service mirrored those that did not have an assigned MMIS provider and/or specialty type.

While several of the CCO's narrative responses referenced documents, there were several elements in which AllCare did not include the supporting documentation as part of its original submission. For instance, the CCO referenced screenshots of its PCP adequacy monthly analysis and its Access Strategy slideshow to demonstrate geographic distribution of all providers compared with the geographic distribution of members. The CCO's narrative response was not comprehensive, resulting in a partially met element. The excluded documents may have contained content to fully demonstrate that the CCO does have a method to compare the geographic distribution of members with providers.

AllCare described how its NEMT vendor, ReadyRide, provides services across the delivery network. The CCO conducts monthly, quarterly, and annual monitoring of the NEMT vendor and member utilization to identify trends and project NEMT needs to ensure adequate capacity. The NEMT vendor submits monthly operations summary reports and graphs that are reviewed by AllCare during its internal quarterly quality meetings. In addition, the CCO receives an NEMT Audit Report that illustrates how members with disabilities or special needs are accommodated, ensuring that all members have access to NEMT services. Information incorporated in the audit report is obtained during assessments conducted by ReadyRide to identify the current and future needs of each AllCare member. The CCO considers access to NEMT for all members adequate.

AllCare described using reports specific to hospital admissions and emergency department utilization as a method of monitoring and ensuring the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day, 7 days a week for all members. The CCO's care coordination team uses this information to conduct member outreach to identify barriers to care, discuss access to care options, provide nurse help line contact information, and make members aware of behavioral health and medical resources available to them through their community mental health provider and/or PCP.

Table A-2 includes the complete AllCare DSN Provider Narrative Report review results.

Table A-2—AllCare Health Plan—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	0.5	**Findings**: AllCare began administering the Third Next Available Appointment (TNAA) survey and collecting data in 2018 and reported being in the process of establishing a baseline metric. The CCO referred to attached surveys and a listening session summary to demonstrate how it monitors access from member feedback, but the supporting documentation was not included with AllCare's original submission. **Recommendation for the Next Submission:** AllCare should provide a narrative that analyzes wait times for appointments with providers, including specialists.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	0.0	**Findings**: AllCare's narrative response referred to the previous element (#1), which described surveying all contracted, in-network providers quarterly. The data are compiled by provider ZIP Code and compared with the current members residing in the same ZIP Code. The CCO uses this monitoring mechanism to identify inadequacies within the network and where to focus contracting efforts; however, calculating by ZIP Code produces an estimate of the time and distance standard for member access to healthcare. In addition, the CCO included an example of providing NEMT to transport a member to

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
			access specialty care; however, the example did not demonstrate its efforts to address local service gaps through telemedicine or video conferencing for specialist consultations. **Recommendation for the Next Submission:** AllCare should provide a narrative describing how the network ensures the time and distance standards for member access to specialists using the precise geographic locations of its members and all providers. In addition, the CCO should provide a narrative that describes its efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	0.0	**Findings**: AllCare's narrative response referenced the ratios included as a response for a different element; however, that information was not included as part of the CCO's DSN submission. The CCO also submitted several policies as supporting documentation; however, none of them were applicable to the element. The CCO did not describe the ratio of members to providers specifically for PCPs, specialists, mental health practitioners, SUD treatment providers, dental care providers, and the availability of acute care beds. The CCO referenced the "AllCare Behavioral Health—Acute and Intensive Services Capacity" document, but this document was also omitted as part of its DSN submission. **Recommendation for the Next Submission:** AllCare should provide a narrative that describes the ratio of members to providers for PCPs, specialists, mental health practitioners, SUD treatment providers, dental care providers, and the availability of acute care beds. The CCO should analyze these ratios—including addressing pediatric, adult, and geriatric providers—and describe whether the

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
			CCO considers these ratios adequate. In addition, AllCare should include all referenced supporting documentation.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	0.5	**Findings**: AllCare described how community health workers, peer support specialists, and peer wellness specialists are incorporated into the delivery network as an integral part of the CCO's care coordination team, contracted community mental health providers, and community agencies; however, the CCO did not describe by type whether the CCO considers this adequate. **Recommendation for the Next Submission:** AllCare should provide a narrative describing whether the amount of THWs (by type) incorporated into its delivery network is considered adequate.
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	0.0	**Findings**: AllCare listed all of the specialists available in its network adequacy model, including acupuncture and physical therapy. The CCO did not describe the availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members. **Recommendation for the Next Submission:** AllCare should provide a narrative that describes the availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.
	Total Score	**9.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	0.0	**Findings**: AllCare described the quarterly report with demographic information (i.e., race, language spoken, age, disability, and rural versus urban) that is generated by its Health Equity and Inclusivity Action Team and used as part of its incentive measures; however, the CCO did not describe its process for taking into account member language and cultural needs and/or disabilities and SHCN when making provider assignments. **Recommendation for the Next Submission:** AllCare should provide a narrative that describes its process for how member language and cultural needs and/or disabilities and SHCN are taken into account when making provider assignments.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	0.5	**Findings**: AllCare described monitoring the prevalence of disease as a component of its quarterly and annual reporting conducted by its Population Health Program. The CCO uses a healthcare analytic tool

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
			to analyze and define member acuity and determine current need and project potential for increasing medical need for specific diseases; however, the CCO did not provide analysis demonstrating the prevalence of diseases that require access to specialists. **Recommendation for the Next Submission:** AllCare should provide analysis that demonstrates the prevalence of diseases that require access to specialists among the member population.
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**1.5**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	0.5	**Findings**: AllCare described how member feedback from its community advisory council and the local Regional Health Equity Coalition is incorporated to improve member access. However, the CCO did not describe how member feedback from complaint and grievance analysis; adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys; and CAHPS surveys are incorporated into network adequacy decisions. **Recommendation for the Next Submission:** AllCare should provide a narrative that addresses how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis; adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys; and CAHPS surveys.

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	0.5	**Findings**: AllCare described how data are used to identify interventions related to Performance Improvement Projects for members with specific age-related health and preventive care needs; however, the CCO did not describe how members receive follow-up and training in self-care, as appropriate, that members may take to promote their own health. **Recommendation for the Next Submission:** AllCare should provide a narrative that describes how members receive follow-up and training in self-care, as appropriate, that members may take to promote their own health.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**3.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
21.	CCO discusses coordination with above stakeholders.	1	Met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

Cascade Health Alliance, LLC

Cascade Health Alliance, LLC (CHA) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Klamath County.

CHA submitted detailed DSN Provider Narrative and Capacity Reports. The DSN Provider Capacity Report included all of the required data fields; however, nine of the 30 OHA predetermined categories of service were excluded. Hospital, Acute Psychiatric Care, Certified or Qualified Health Care Interpreters, Community Prevention Services, Health Education, Health Promotion, Health Literacy; Mental Health Crisis Services; and Urgent Care Center were a few of the excluded services. Five of the missing categories of service mirrored those that did not have an assigned MMIS provider and/or specialty type.

CHA's established Provider Network Management Committee oversees monitoring and concerns related to the CCO's delivery network adequacy. Access-related member grievances, customer service call data, and service area validation call results are reviewed by the Provider Network Management Committee. Access-related member grievances, customer service call data, service area validation call results, CAHPS survey results, and results from the "secret shopper" calls to inquire about next appointment PCP and specialist availability are all reviewed by the Provider Network Management Committee. If a concern or non-compliance with a contractual agreement or standard are identified, a corrective action plan with strategies, deliverables, and dates will be implemented and monitored by the committee.

While CHA described the four partnerships in place that incorporate THWs into its delivery network, the CCO did not describe whether the current amount of THWs incorporated into its delivery network is considered adequate.

The CCO demonstrated its commitment to ensuring appropriate services for each member with disabilities, cultural needs, linguistic needs, and/or SHCN. CHA developed a dashboard that provides CHA staff members with a broad picture of what the membership looks like and its needs, including age and gender breakdown, number of members with a disability, total number of those considered to have SHCN, those with a severe or persistent mental illness, and those who speak or write another language aside from English.

Table A-3 provides the complete CHA DSN Provider Narrative Report review results.

Table A-3—Cascade Health Alliance—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	Met
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	1	Met
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met

Indicator		Score	Findings/Recommendations
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met
	Total Score	**12.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**3.0**	**Out of Possible 3.0**

Indicator		Score	Findings/Recommendations
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	1	Met
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**4.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met
21.	CCO discusses coordination with above stakeholders.	1	Met

Indicator		Score	Findings/Recommendations
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

Columbia Pacific CCO, LLC

Columbia Pacific CCO, LLC (CPCCO) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Catsop, Columbia, and Tillamook counties.

CPCCO submitted detailed DSN Provider Narrative and Capacity Reports that included all of the required data fields and all 30 OHA predetermined categories of service.

CPCCO described its various mechanisms used to monitor and analyze appointment wait times with providers, including specialists, across several internal departments and committees. For instance, the Provider Relations department conducts routine surveys to assess appointment availability and analysis. The CCO used the results to establish and monitor an average number of days for a new patient, existing patient, and urgent/emergent appointment. In addition, the CCO's dental and behavioral health partners conduct routine monitoring and report back to the CCO for oversight.

CPCCO provided ratios of providers to adult members for primary care, specialty, OB/GYN, and dental providers. The CCO also described the ratio of members to behavioral health providers; however, this ratio should be categorized by members to mental health and SUD treatment providers. The ratio of acute care beds was also not addressed. In addition, the CCO did not describe provider ratios specific to care rendered to pediatric members.

Table A-4 includes the complete CPCCO DSN Provider Narrative Report review results.

Table A-4—Columbia Pacific CCO—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	0.5	**Findings:** CPCCO described ratios of providers to adult and pediatric members for primary care, specialty, and dental providers. The CCO also described the ratio of members to behavioral health providers; however, this ratio should be stratified by members to mental health and SUD treatment providers. In addition, the CCO did not describe the mental health practitioner and SUD provider ratios specific to care rendered by pediatric providers to members within those populations. The availability of acute care beds was also not addressed in the CCO's narrative response. **Recommendation for the Next Submission:** CPCCO should individually analyze and describe the ratios of adult and pediatric members to mental health and SUD providers. The CCO should also address the availability of acute care beds.

Indicator		Score	Findings/Recommendations
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	1	Met
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met
	Total Score	**11.5**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met

Indicator		Score	Findings/Recommendations
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**3.0**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	1	Met
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**4.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met

Indicator		Score	Findings/Recommendations
21.	CCO discusses coordination with above stakeholders.	1	Met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

Eastern Oregon CCO

Eastern Oregon CCO (EOCCO) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Baker, Gilliam, Grant, Harney, Lake, Malheurs, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler counties.

EOCCO submitted a DSN Provider Narrative and Capacity Reports that reflected the template. The CCO submitted several supplementary documents to describe and demonstrate the monitoring, reporting, and analysis of its delivery service network. The DSN Provider Capacity Report included all of the required data fields; however, five of the 30 OHA predetermined categories of service were excluded. Four of the five missing categories of service mirrored those that did not have an assigned MMIS provider and/or specialty type, the other excluded service was Hospital, Acute Psychiatric Care.

The CCO described its analytic reporting software platform that links directly to its individual clinic's electronic medical records (EMRs). The software aggregates data from multiple sources and combines clinical, utilization, cost, and demographic information. EOCCO uses the exported reports and visual tools for monitoring quality improvement, outcomes, and cost containment. In addition, the CCO described its use of the Arcadia Analytics platform. This software allows providers to receive a high-level and integrated view of member-specific utilization. The data are turned into actionable information through dashboards, alerts, gap in service notifications, report writing capabilities, and trend charts.

While EOCCO described the ratio of member to providers for PCPs, PCPCH providers, behavioral health physicians, doctoral and non-doctoral providers, the CCO should have separated behavioral health to member analysis by mental health and SUD treatment providers; however, the CCO did not analyze and describe the member to dental care provider ratio; the availability of acute care beds ratio; and ratios specific to providers that render care to pediatric, adult, and geriatric members.

Table A-5 provides the complete EOCCO DSN Provider Narrative Report review results.

Table A-5—Eastern Oregon CCO—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	0.5	**Findings**: EOCCO discussed and demonstrated how its network ensures time and distance standards for member access to specialists; however, the narrative or supporting documentation did not mention the CCO's efforts to address local service gaps through telemedicine or video conferencing for specialist consultations. **Recommendation for the Next Submission:** EOCCO should provide a narrative that describes the CCO's efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	0.5	**Findings:** EOCCO described the ratio of members to PCPs and PCPCH providers. The CCO also described the ratio of members to behavioral health physicians, doctoral and non-doctoral providers; however, this ratio should be stratified by member to mental health and SUD treatment providers. EOCCO did not address the member to dental care provider ratio or the availability of acute care beds ratio. In

Indicator		Score	Findings/Recommendations
			addition, the CCO did not address ratios specific to providers that render care to pediatric, adult, and geriatric member populations. **Recommendation for the Next Submission:** EOCCO should provide a narrative that describes the member-to-provider ratios for mental health, SUD treatment, and dental healthcare providers, as well as the availability of acute care beds. The CCO should also address ratios of members to pediatric, adult, and geriatric providers. In addition, EOCCO should describe and demonstrate whether the ratios are considered adequate.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	1	Met
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met

Indicator		Score	Findings/Recommendations
	Total Score	**11.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**3.0**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	1	Met
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met

Indicator		Score	Findings/Recommendations
	Total Score	**4.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met
21.	CCO discusses coordination with above stakeholders.	1	Met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

Health Share of Oregon

Health Share of Oregon (HSO) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Clackamas, Multnomah, and Washington counties.

HSO submitted a detailed DSN Provider Capacity Report that included all of the required data fields and all 30 OHA predetermined categories of service. The CCO provided written descriptions to identify the four categories of service that did not have assigned MMIS provider and/or specialty types.

A separate DSN Provider Narrative Report was submitted with all of the of the required categories and elements reflected in the OHA template. HSO's report included comprehensive descriptions of its daily operations and monitoring activities to demonstrate member access and the adequacy of its delivery system network. HSO achieved a score of *Met* for each element across all five categories.

HSO described the use of an internal enterprise data warehouse, Health Share Bridge, that serves as a host for five other applications, making real-time member information available. Member geographic, enrollment, and utilization data are populated daily in the platform, offering an aggregated overview of member needs from geographic, time/distance, racial, ethnic, and linguistic perspectives. This tool is accessible to HSO's plan partners and network providers for the purpose of population management and coordinating services. Several of HSO's delegated plan partners also use geocoding software to monitor compliance and determine strategies to address delivery network gaps. The CCO embedded several analytic charts and graphics demonstrating delivery network adequacy and population management of its members and various conditions.

A collaborative effort with the CCO's CAC and the Healthy Columbia Willamette Collaborative created and released the 2018–2020 Community Health Needs Assessment. Through member and community engagement, the assessment included HSO aggregated member condition/illness data, identified health needs, community strengths, prevalence of disease, and potential future programs to best meet the needs of the communities HSO serves.

Table A-6 provides the complete HSO DSN Provider Narrative Report review results.

Table A-6—Health Share of Oregon—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	Met
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	1	Met
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met

Indicator		Score	Findings/Recommendations
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met
	Total Score	**12.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**3.0**	**Out of Possible 3.0**

Indicator		Score	Findings/Recommendations
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	1	Met
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**4.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met
21.	CCO discusses coordination with above stakeholders.	1	Met

Indicator		Score	Findings/Recommendations
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

InterCommunity Health Network CCO

InterCommunity Health Network CCO (IHN CCO) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Lincoln, Benton, and Linn counties.

IHN CCO submitted a comprehensive DSN Provider Capacity Report that included all of the required data fields; however, seven of the 30 OHA predetermined categories of service were excluded. Hospital, Acute Psychiatric Care; Indian Health Services and Tribal Health Clinics; and School-based Health Centers were a few of the excluded services. Four of the missing categories of service mirrored those that did not have an assigned MMIS provider and/or specialty type.

The CCO provided multiple supplemental documents to demonstrate various monitoring activities described in its narrative; however, there were several instances in which the CCO did not respond to the element in its entirety, resulting in several partially met elements. For instance, IHN CCO described analyzing EHR data to identify gaps in care, grievances, and member utilization, and reviewing patient experience surveys to identify patient needs, provider educational opportunities, and develop strategies to improve member care. The CCO's response did not specifically describe how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis; adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys; and CAHPS surveys. The narrative also lacked a description of how it uses the input from its CAC.

IHN CCO used geocoding to identify service gaps in its network delivery system. IHN CCO submitted its written process for assessing provider network adequacy and a sample network adequacy report to demonstrate member access to services and its analysis.

While IHN CCO partners with various social and support agencies to increase communication and coordination of referrals for physical, dental, and mental health services for its membership, the CCO did not specifically describe its relationships (including any memoranda of understanding) with Aging and Persons with Disabilities, the local public health authority, the local mental health authority, and IHS and/or Tribal Health Clinics or how it coordinates member care with these stakeholders.

Table A-7 provides the complete IHN CCO DSN Provider Narrative Report review results.

Table A-7—InterCommunity Health Network CCO—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	0.0	**Findings**: IHN CCO did not describe current mechanisms for monitoring and analyzing appointment wait times for providers, including specialists; however, the CCO described a new process for monitoring and analyzing appointment wait times for providers, including specialists, through its recently acquired EMR database that is set to be implemented in 2019. **Recommendation for the Next Submission:** IHN CCO should describe mechanisms for analyzing appointment wait times for providers, including specialists.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met

	Indicator	Score	Findings/Recommendations
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	Met
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	0.5	**Findings**: IHN CCO described how THWs are incorporated throughout its network, employed by the CCO, contracted providers, and community stakeholders in the roles of community health workers, peer wellness specialists, certified personal health navigators, and doulas. The CCO described that there was no protocol or mechanism in place to analyze the ratio of THWs and did not determine if the available services are adequate to meet the needs of its members. **Recommendation for the Next Submission:** IHN CCO should analyze THW by type and describe whether the CCO considers the services adequate to meet the needs of its members.
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	0.5	**Findings**: IHN CCO described using grievances/complaints to monitor NEMT and identify opportunities for process improvement; however, the CCO did not describe how NEMT is provided across its delivery network. **Recommendation for the Next Submission:** IHN CCO should provide a narrative describing how NEMT is provided across its delivery network.
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met

	Indicator	Score	Findings/Recommendations
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	0.5	**Findings**: IHN CCO described contracted services available to treat mental health disorders; however, the CCO's monitoring and analysis of its utilization management reports identified inadequate capacity that impacts the continuum of care with youth respite, adult and youth access to psychiatrists, adult outpatient services, and Behavioral Rehabilitation System (BRS) bed availability. The CCO described working diligently to coordinate care and identify alternative care options to ensure that the members' needs are met. IHN CCO described working on recruitment and retainment of mental health providers to expand access to care. **Recommendation for the Next Submission:** IHN CCO should provide a narrative that demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	0.0	**Findings**: IHN CCO did not demonstrate a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of SUDs. The CCO identified an inadequate capacity of SUD residential and detox services and referred to the same capacity issues identified for treatment of mental health disorders. **Recommendation for the Next Submission:** IHN CCO should provide a narrative that demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of SUDs.

Indicator		Score	Findings/Recommendations
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	0.5	**Findings**: IHN CCO described that acupuncturists, chiropractors, and physical therapy services are available through its delivery network and, if necessary, other medically necessary alternative therapies are authorized and available from non-contracted providers; however, the CCO did not describe whether the available services are adequate to meet the needs of its members. **Recommendation for the Next Submission:** IHN CCO should provide a narrative addressing whether the alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) available in its network are adequate to meet the needs of its members.
	Total Score	**8.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	0.5	**Findings**: IHN CCO described that member characteristics are not taken into account when making provider assignments. The CCO submitted a Household Language Report that demonstrated the monthly analysis conducted by the CCO; however, the CCO did not provide analysis of the needs of members with disabilities as well as cultural needs and SHCN. **Recommendation for the Next Submission:** IHN CCO should provide a narrative that addresses how member characteristics are taken into account when making provider assignments. The CCO should also provide an analysis conducted to identify the needs of its members as they relate to disabilities as well as cultural and SHCN.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met

Indicator		Score	Findings/Recommendations
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**2.5**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	0.5	**Findings**: IHN CCO described analyzing EHR data to identify gaps in care, grievances, member utilization, and "patient experience surveys" to identify patient needs, provider educational opportunities, and develop strategies to improve member care. The CCO's response did not specifically describe how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis; adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys; and CAHPS surveys results. The narrative also lacked a description of how it uses the input from its community advisory council. **Recommendation for the Next Submission:** IHN CCO should provide a narrative that describes how the CCO incorporates member feedback into network adequacy decisions, including complaint and grievance analysis; adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys; and CAHPS surveys. In addition, the CCO should describe how it uses the input from its community advisory council.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met

	Indicator	Score	Findings/Recommendations
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**3.5**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	0.0	**Findings**: IHN CCO described how it partners with various social and support agencies to increase communication and coordination of referrals between the agencies for physical, dental, and mental health services for its membership; however, the CCO did not specifically describe a relationship (including any memoranda of understanding) with Aging and Persons with Disabilities, the local public health authority, the local mental health authority, and IHS and/or Tribal Health Clinics. **Recommendation for the Next Submission:** IHN CCO should provide a narrative that describes its relationship (including any memoranda of understanding) with Aging and Persons with Disabilities, the local public health authority, the local mental health authority, and IHS and/or Tribal Health Clinics.
21.	CCO discusses coordination with above stakeholders.	0.0	**Findings**: IHN CCO described how it partners with various social and support agencies to increase communication and coordination of referrals between the agencies for physical, dental, and mental health services for its membership; however, the CCO did not specifically describe how it coordinates with Aging and Persons with Disabilities, the local public health authority, the local mental health authority, and IHS and/or Tribal Health Clinics. **Recommendation for the Next Submission:** IHN CCO should provide a narrative addressing how it coordinates with Aging and Persons with Disabilities, the local public health authority, the local mental health authority, and IHS and/or Tribal Health Clinics.

Indicator		Score	Findings/Recommendations
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**3.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

Jackson Care Connect

Jackson Care Connect (JCC) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Jackson County.

JCC submitted detailed Provider Narrative and Provider Capacity Reports that included all of the required data fields and all 30 OHA predetermined categories of service.

JCC described how THWs are incorporated in its delivery network in varying roles—such as health resilience specialists (HRSs), doulas, community health workers, peer specialists, and family support specialists—employed by the CCO, contracted providers, and community stakeholders. The CCO described how HRSs are embedded within high volume clinics to assist high utilizing members navigate the delivery system and eliminate barriers. JCC reported hiring culturally specific and multi-lingual staff members and embedding them in the clinics that serve the corresponding diverse populations.

The CCO described and provided several examples of programs available to promote member self-care with specific healthcare needs. JCC has an established partnership with the local Young Men's Christian Association (YMCA) and its wellness programs. The partnership includes peer supports, exercise programs, education, and encouragement for adults and youths between the ages of nine and 14. Members can also access the Nutrition Workshop for Healthy Eating. All services were offered at no cost to the member.

JCC described how member feedback from its CAC and access-related grievances and complaints monitored by its Quality Assurance department are incorporated into network adequacy decisions; however, the CCO did not address how feedback from adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys, and CAHPS surveys are incorporated.

Table A-8 provides the complete JCC DSN Provider Narrative Report review results.

Table A-8—Jackson Care Connect—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	0.5	**Findings:** JCC provided ratios of providers to adult and pediatric members for primary care, specialty, and dental providers. The CCO also described the ratio of members to behavioral health providers; however, this ratio should be categorized by members to mental health and SUD treatment providers. In addition, the CCO did not describe mental health and SUD provider ratios specific to care rendered to pediatric members. The availability of acute care beds was also not addressed in the CCO's narrative response. **Recommendation for the Next Submission:** JCC should individually analyze and describe the ratio of adult and pediatric members to mental health and SUD providers. The CCO should also address the availability of acute care beds.

Indicator		Score	Findings/Recommendations
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	1	Met
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	0.5	Met
	Total Score	**11.5**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met

	Indicator	Score	Findings/Recommendations
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**3.0**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	0.5	**Findings:** JCC described how member feedback from its CAC and access-related grievances and complaints monitored by its Quality Assurance department are incorporated into network adequacy decisions; however, the CCO did not address how feedback from adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys and CAHPS surveys results are incorporated. **Recommendation for the Next Submission:** JCC should provide a narrative that addresses how it incorporates member feedback, including complaint and grievance analysis; adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys; and CAHPS survey results into network adequacy decisions.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**3.5**	**Out of Possible 4.0**

Indicator		Score	Findings/Recommendations
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met
21.	CCO discusses coordination with above stakeholders.	1	Met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

PacificSource Community Solutions–Central Oregon

PacificSource Community Solutions–Central Oregon (PSCS-CO) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Deschutes, Crook, Jefferson, and parts of Klamath counties.

PSCS-CO submitted detailed DSN Provider Narrative and Capacity Reports. The DSN Provider Capacity Report included all of the required data fields; however, seven of the 30 OHA predetermined categories of service were excluded. Hospital, Acute Psychiatric Care; HIS and/or Tribal Health Clinic; and Palliative Care were a few of the excluded services. Four of the missing categories of service mirrored those that did not have an assigned MMIS provider and/or specialty type.

The CCO provided a thorough description of how PSCS-CO ensures member access and conducts analysis. PSCS-CO conducts an annual comprehensive quantitative analysis of the provider network (all provider types) to identify network strengths and deficiencies. The CCO also conducted quarterly access to care surveys for both physical and behavioral health providers. PSCS-CO also monitored ongoing analysis of its dental care organization (DCO) services by monitoring monthly utilization trends, quarterly dental provider capacity reports, quarterly appointment access reports, and weekly emergency room usage for non-traumatic dental reasons. In addition, PSCS-CO educated its delivery network providers via biannual workshops and provider newsletters regarding member access to urgent, emergency, crisis, and triage services 24 hours a day, 7 days a week for all members.

PSCS-CO described using OHA 834 demographic information and its internal Member Insight Report to ensure that the members' language and cultural needs, disabilities, and SHCN are taken into account when making provider assignments; however, the CCO did not provide analysis of its members' language and cultural needs, disabilities, and SHCN.

Table A-9 provides the complete PSCS-CO DSN Provider Narrative Report review results.

Table A-9—PacificSource Community Solutions–Central Oregon—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	0.5	**Findings**: PSCS-CO described and analyzed the ratios of members to primary care, specialty, and dental care providers. The CCO considered the ratios adequate for two of the three, identifying opportunities to improve the member ratio specific to allergy, asthma and immunology services. The CCO also described the ratio of members to behavioral health providers; however, this ratio should be stratified by members to mental health and SUD treatment providers. PSCS-CO did not address the ratio of acute care beds. In addition, the CCO did not describe ratios specific to providers that render care to pediatric, adult, and geriatric member populations. **Recommendation for the Next Submission:** PSCS-CO should analyze and describe the ratio of members to mental health and SUD providers, instead of categorizing these services

	Indicator	Score	Findings/Recommendations
			together as behavioral health. The CCO should describe ratios specific to providers that render care to pediatric, adult, and geriatric member populations.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	0.5	**Findings**: PSCS-CO described the types of THWs incorporated into its delivery network and the initiatives in place to expand member access and availability to THW; however, the CCO did not describe whether the current amount of THWs incorporated into its delivery network is considered adequate. **Recommendation for the Next Submission:** PSCS-CO should analyze and describe by type whether the CCO considers the available THWs to be adequate.
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met

Indicator		Score	Findings/Recommendations
	Total Score	**11.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	0.5	**Findings**: PSCS-CO described the use of 834 demographic information and the CCO's Member Insight Report to ensure that the members' language and cultural needs, disabilities, and SHCN are taken into account when making provider assignments; however, the CCO did not provide analysis of its members' language and cultural needs, disabilities, and SHCN. **Recommendation for the Next Submission:** PSCS-CO should provide analysis of its members' language and cultural needs, disabilities, and SHCN.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**2.5**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	0.5	**Findings**: PSCS-CO described its review of the complaint and grievance analysis; adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys; and CAHPS survey results. In addition, the CCO held focus groups with the CAC to gain insight on its members' personal experiences. The CCO did not describe how any of the above member feedback is incorporated into network adequacy decisions. The CCO also did not describe how input from the community advisory council is used. **Recommendation for the Next Submission:** PSCS-CO should provide a narrative that describes how member feedback—including complaint and grievance analysis; adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys; and CAHPS survey results— are incorporated into network adequacy

Indicator		Score	Findings/Recommendations
			decisions. In addition, the CCO should describe how input from the community advisory council is used.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	0.5	**Findings**: PSCS-CO described the role of the nurse case manager as it pertains to telephonic screenings and care plan development for members identified regarding care coordination, cultural factors, and social determinants of health needs; however, the narrative response did not address how follow-up and training in self-care are incorporated to ensure and promote each member's own health. **Recommendation for the Next Submission:** PSCS-CO should describe procedures used to ensure that members with specific healthcare needs receive follow-up, training in self-care, and other interventions, as appropriate, to promote their own health.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**3.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met
21.	CCO discusses coordination with above stakeholders.	1	Met

Indicator		Score	Findings/Recommendations
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

PacificSource Community Solutions–Columbia Gorge

PacificSource Community Solutions–Columbia Gorge (PSCS-CG) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Hood River and Wasco counties.

PSCS-CG submitted detailed DSN Provider Narrative and Capacity Reports. The DSN Provider Capacity Report included all of the required data fields; however, seven of the 30 OHA predetermined categories of service were excluded. Hospital, Acute Psychiatric Care; Indian Health Services and Tribal Health Clinic; and Palliative Care were a few of the excluded services. Five of the missing categories of service mirrored those that did not have an assigned MMIS provider and/or specialty type.

The CCO is involved with Project ECHO (Extension for Community Healthcare Outcomes), a collaborative model of medical education and care management that empowers clinicians to provide better care to more people. This project model engages clinicians in a continuous learning system and partners them with specialist mentors, providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions such as: hepatitis C, human immunodeficiency virus (HIV), tuberculosis, chronic pain, endocrinology, behavioral health disorders, and many others. Project ECHO increases access to specialty treatment for members residing in rural and underserved areas.

PSCS-CG described and analyzed the ratios of members to primary care, specialty, and dental care providers. The CCO considered the ratios adequate for two of the three, identifying opportunities to improve the member ratio specific to allergy, asthma, and immunology services. The CCO also described the ratio of members to behavioral health providers; however, this ratio should be categorized by members to mental health and SUD treatment providers. The ratio of acute care beds was also not addressed. Of the ratios described, PSCS-CG did not address the specialty care, mental health, and SUD treatment provider ratios specific to care rendered to pediatric, adult, and geriatric members.

Table A-10 provides the complete PSCS-CG DSN Provider Narrative Report review results.

Table A-10—PacificSource Community Solutions–Columbia Gorge—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	0.5	**Findings**: PSCS-CG described and analyzed the ratios of members to primary care, specialty, and dental care providers. The CCO considered the ratios adequate for two of the three, identifying opportunities to improve the member ratio specific to allergy, asthma and immunology services. The CCO also described the ratio of members to behavioral health providers; however, this ratio should be stratified by members to mental health and SUD treatment providers. PSCS-CG did not address the ratio of acute care beds. In addition, the CCO did not address ratios specific to providers that render care to pediatric, adult, and geriatric member populations. **Recommendation for the Next Submission:** PSCS-CG should analyze and describe the ratio of members to mental health and SUD treatment providers, instead of categorizing these

	Indicator	Score	Findings/Recommendations
			services together as behavioral health. The CCO should also address ratios specific to providers that render care to pediatric, adult, and geriatric member populations.
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	0.5	**Findings**: PSCS-CG described the types of THWs incorporated into its delivery network and the initiatives in place to expand member access and availability to THWs; however, the CCO did not describe by type whether the CCO considers this adequate. **Recommendation for the Next Submission:** PSCS-CG should provide a narrative describing whether the THWs incorporated into its delivery network is considered adequate.
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met

Indicator		Score	Findings/Recommendations
	Total Score	**11.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	0.5	**Findings**: PSCS-CG described the use of 834 demographic information and the CCO's Member Insight Report to ensure that the members' language and cultural needs, disabilities, and SHCN are taken into account when making provider assignments; however, the CCO did not provide analysis of its members' language and cultural needs, disabilities, and SHCN. **Recommendation for the Next Submission:** PSCS-CG should provide analysis of its members' language and cultural needs, disabilities, and SHCN.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**2.5**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	0.5	**Findings**: PSCS-CG described its review of the complaint and grievance analysis; adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys; and CAHPS survey results. In addition, the CCO held focus groups with the CAC to gain insight on its members' personal experiences. The CCO did not describe how any of the above member feedback is incorporated into network adequacy decisions. The CCO also did not describe how input from the community advisory council is used. **Recommendation for the Next Submission:** PSCS-CG should provide a narrative that describes how member feedback—including the complaint and grievance analysis; adult (MHSIP), family (YSS-F), and child (YSS) mental health surveys; and CAHPS survey results—are incorporated into network adequacy

Indicator		Score	Findings/Recommendations
			decisions. In addition, the CCO should describe how input from the community advisory council is used.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	0.5	**Findings**: PSCS-CG described the role of the nurse case manager as it pertains to telephonic screenings and care plan development for members identified regarding care coordination, cultural factors, and social determinants of health needs; however, the narrative response did not address how follow-up and training in self-care are incorporated to ensure and promote each member's own health. **Recommendation for the Next Submission:** PSCS-CG should describe procedures used to ensure that members with specific healthcare needs receive follow-up, training in self-care, and other interventions, as appropriate, to promote their own health.
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**3.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met

Indicator		Score	Findings/Recommendations
21.	CCO discusses coordination with above stakeholders.	1	Met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

PrimaryHealth

PrimaryHealth (PH) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Josephine County.

PH submitted detailed DSN Provider Narrative and Capacity Reports. The DSN Provider Capacity Report included all of the required data fields; however, nine of the 30 OHA predetermined categories of service were excluded. Hospital, Acute Psychiatric Care; Home Health; NEMT; and Palliative Care were excluded from the report. Five of the missing categories of service mirrored those that did not have an assigned MMIS provider and/or specialty type.

The CCO's narrative responses were detailed and included the required analysis. For instance, PH described the use of several monitoring mechanisms to ensure members have access to provider appointments in a timely manner. The CCO used "secret shopper" calls, appointment availability survey calls, monitoring of grievances classified as access to care related issues, ongoing oversight, and completion of annual attestations of subcontractors with delegated responsibilities. If deficiencies are identified, PH will implement its formal corrective action plan and the CCO's Quality and Compliance Committee conducts oversight.

PH described several mechanisms in place to identify and gather member characteristics such as chronic risk factors, SHCN, language or communication needs, cultural preferences, and chronic conditions. One method is the "Welcome Call," which is made to every new member. The CCO gathers member characteristics from the screening questions and helps to inform and assign members to clinics that are nearest to their homes or providers that are skilled in caring for their age group or specific diagnosis.

The CCO described the contract status and established relationships with Aging and Persons with Disabilities, local public health authorities, local mental health authorities, and IHS and/or Tribal Health Clinics; however, the CCO briefly described mechanisms used to coordinate member care but did not expand on how care is coordinated directly with each mentioned stakeholder.

Table A-11 provides the complete PH DSN Provider Narrative Report review results.

Table A-11—PrimaryHealth—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	Met
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	1	Met
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met

Indicator		Score	Findings/Recommendations
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met
	Total Score	**12.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**3.0**	**Out of Possible 3.0**

Indicator		Score	Findings/Recommendations
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	1	Met
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**4.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met
21.	CCO discusses coordination with above stakeholders.	0.5	**Findings:** PH described the established relationships and contract status with Aging and Persons with Disabilities, the local public health authority, the local mental health authority, and IHS and/or Tribal Health Clinics. The CCO described some mechanisms used to

Indicator		Score	Findings/Recommendations
			coordinate member care but did not specifically discuss how care is coordinated directly with the stakeholders. **Recommendation for the Next Submission:** PH should provide a narrative that discusses how the CCO coordinates with Aging and Persons with Disabilities, the local public health authority, the local mental health authority, and IHS and/or Tribal Health Clinics.
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	0.5	**Findings:** PH described the use of PH TECH's Clinical Integration Manager (CIM) portal to coordinate care across its provider network with the use of two-way communication between CCO care teams and all provider types to assist with transitions across the continuum of care; however, the CCO did not address how it uses EHRs to coordinate preventive healthcare for all members. **Recommendation for the Next Submission:** PH should provide a narrative that discusses how the CCO uses EHRs to coordinate preventive healthcare for all members.
	Total Score	**4.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

Trillium Community Health Plan, Inc.

Trillium Community Health Plan, Inc. (TCHP) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Lane County and part of Douglas County.

TCHP submitted detailed DSN Provider Narrative and Provider Capacity Reports. The DSN Provider Capacity Report included all of the required data fields; however, six of the 30 OHA predetermined categories of service were excluded. Hospital, Acute Psychiatric Care; Palliative Care; and School-based Health Centers were some of the excluded services. Four of the missing categories of service mirrored those that did not have an assigned MMIS provider and/or specialty type.

The CCO reported producing network adequacy reports at least annually, or when a material change occurs to ensure that time and distance standards are being met or that potential changes will not impact member access. In addition to the network adequacy report, the CCO's Quality Improvement Committee reviews geo-network analysis, CAHPS survey results, and grievances and appeals, and makes network adequacy recommendations and decisions based on the findings.

TCHP described assessing and identifying member characteristics, including language and cultural needs and the needs of those with disabilities and SHCN. In addition, the CCO's narrative response included thorough analysis of its membership's need, which is taken into account when making provider assignments.

TCHP uses TrueCare as an EMR system that allows all departments access to member records within the scope of their position, including a flow of charting of clinical and non-clinical interactions in an effort to reduce duplication of services. In addition, a member health record is accessible to providers through the secure provider portal. This record provides actionable information in a manner and format that allows providers to view clinical history, individualized care plans, and current interventions on their members.

Table A-12 provides the complete TCHP DSN Provider Narrative Report review results.

Table A-12—Trillium Community Health Plan—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	Met

	Indicator	Score	Findings/Recommendations
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	0.5	**Findings:** TCHP described the role of THWs within its organization by type and count. THWs support member coordination of care, assisting with the completion of HRAs for SHCN members, and serving as CCO representatives on committees with community partners that address health disparities and health equity; however, the CCO reported not having a process in place to analyze the needs of its membership as it relates to the adequacy of THWs within its delivery network. **Recommendation for the Next Submission:** TCHP should provide a description that states whether the THWs incorporated into its delivery network are considered adequate.
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met

	Indicator	Score	Findings/Recommendations
	Total Score	**11.5**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**3.0**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	1	Met
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met

Indicator		Score	Findings/Recommendations
	Total Score	**4.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met
21.	CCO discusses coordination with above stakeholders.	1	Met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

Umpqua Health Alliance, LLC

Umpqua Health Alliance, LLC (UHA) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Douglas County.

UHA submitted detailed DSN Provider Narrative and Capacity Reports. The DSN Provider Capacity Report included all of the required data fields and all 30 OHA predetermined categories of service.

UHA circulated an Access to Care survey to PCPs, specialists, DCOs, and behavioral care network providers monthly to determine network adequacy, including appropriate appointment times. The CCO's Network Performance Committee reviews the survey results, discussing compliance with appointment wait times access. In the event delivery network deficiencies are identified, the committee takes immediate action to resolve any gaps in access and care.

The CCO incorporates the use of InterQual to help case management staff members review and determine the appropriate member level of care. In addition, the CCO has a transition of care tool built into its EHR system. This tool facilitates the decision-making process as it relates to discharge planning based on each member's needs. Additional supports for the transitions between levels of care include transportation, home health services, follow-up appointments with both behavioral health or physical health providers, durable medical equipment, and long-term placement.

While UHA described how its Case Management department identifies members for coordination of care, discharge planning, and manages them through different levels of care, the CCO excluded analysis of the prevalence of diseases that require access to specialists as part of its narrative response.

Table A-13 provides the complete UHA DSN Provider Narrative Report review results.

Table A-13—Umpqua Health Alliance, LLC—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	Met
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	1	Met
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met

Indicator		Score	Findings/Recommendations
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met
	Total Score	**12.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	0.5	**Finding:** UHA described how its Case Management department identifies members for coordination of care and discharge planning, and manages them across different levels of care; however, the CCO did not include analysis of the prevalence of diseases that require access to specialists.

Indicator		Score	Findings/Recommendations
			Recommendation for the Next Submission: UHA should provide a narrative that includes analysis of the prevalence of diseases that require access to specialists among its member population.
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**2.5**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	1	Met
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**4.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority	1	Met

Indicator		Score	Findings/Recommendations
	• Local mental health authority • IHS and/or Tribal Health Clinics		
21.	CCO discusses coordination with above stakeholders.	1	Met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

Willamette Valley Community Health, LLC

Willamette Valley Community Health, LLC (WVCH) contracts with OHA to provide physical, behavioral, and dental health services to members residing in parts of Polk and Marion counties.

WVCH's DSN Provider Capacity Report was submitted in six separate tabs for various provider specialty and facility types (i.e., physical health, mental health, transportation, and three separate reports for each DCO). The mental health report did not reflect the practitioner type and practitioner specialty codes in their respective data fields. In addition, several required categories of service including Hospital, Acute Psychiatric Care; Ambulance and Emergency Medical Transportation; and Rural Health Centers were excluded from the report. Three other missing categories of service mirrored those that did not have an assigned MMIS provider type and/or specialty code.

WVCH's provider narrative response described its established processes in place to assess and validate these provisions with a systematic review of appeals and grievances, PCP shopping test calls, and utilization data. In addition, both mental and dental health partners ensure timely access to triage and after-hours care. WVCH considered the urgent, emergency, crisis, and triage services available to members 24 hours a day, 7 days a week to be adequate. The CCO reinforces this expectation across its delivery network by incorporating language in the provider contract that physical health offices must provider triage services 24 hours a day, 7 days a week for all members.

In partnership with Marion and Polk counties' public health departments, WVCH created a community health profile that identified health indicators and the prevalence of diseases impacting members and the greater population of both counties; however, the CCO did not provide analysis demonstrating the prevalence of diseases that require access to specialists.

WVCH described multiple activities that demonstrate its commitment to culturally and linguistically appropriate services. The CCO contracted with 10 agencies to provide certified interpreters for members that are non-English speaking, hearing impaired, or those with challenges communicating verbally or in writing. The CCO participated in and actively supports the Marion Polk Health Equity Coalition, along with the county health departments and other community leaders, with the interest in eliminating cultural and linguistic disparities.

Table A-14 provides the complete WVCH DSN Provider Narrative Report review results.

Table A-14—Willamette Valley Community Health, LLC—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	Met
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	1	Met
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met

Indicator		Score	Findings/Recommendations
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met
	Total Score	**12.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	0.5	**Findings:** In partnership with the Marion and Polk counties' public health departments, WVCH created a community health profile that identified health indicators and the prevalence of diseases impacting members and the greater population of both counties; however, the CCO did not provide analysis demonstrating the prevalence of diseases that require access to specialists.

	Indicator	Score	Findings/Recommendations
			Recommendation for the Next Submission: WVCH should provide a narrative that includes analysis of the prevalence of diseases that require access to specialists.
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**2.5**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	1	Met
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**4.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met

Indicator		Score	Findings/Recommendations
21.	CCO discusses coordination with above stakeholders.	1	Met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

Yamhill Community Care Organization

Yamhill Community Care Organization (YCCO) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Yamhill County, and parts of Clackamas, Washington, Polk, Marion, and Tillamook counties.

YCCO submitted detailed DSN Provider Narrative and Capacity Reports. The DSN Provider Capacity Report included all of the required data fields; however, 11 of the 30 OHA predetermined categories of service were excluded. Ambulance and Emergency Medical Transportation, NEMT, Palliative Care, and Pharmacies were a few of the excluded services. Five of the missing categories of service mirrored those that did not have an assigned MMIS provider and/or specialty type.

YCCO described the use of a complex algorithm that takes a variety of factors into consideration when making provider assignments, such as member language needs, continuity of care, family assignments, clinic capacity, and location. In addition, the CCO's care teams, oral health customer service, and behavioral health delegate have that ability to reassign members to the most appropriate provider that will best address their needs.

The CCO provided an analysis of general behavioral services and coordination of service available through its delivery network; however, it did not demonstrate the continuum of care for the treatment of mental health disorders (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient) and the treatment of SUDs (adult/child, detox, outpatient, intensive outpatient, residential).

YCCO's QCAP reviews and discusses underutilization and overutilization data. When trends are identified, QCAP will make suggestions and operationalize a plan of action. The CCO described workgroups that were formed to address trends in emergency room overutilization and underutilization of preventive services.

Table A-15 provides the complete YCCO DSN Provider Narrative Report review results.

Table A-15—Yamhill Community Care Organization—DSN Provider Narrative Report Review Results

Indicator		Score	Findings/Recommendations
Description of Delivery Network and Adequacy			
1.	CCO describes the geographic distribution of all providers compared with the geographic distribution of members. The CCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	CCO analyzes access and describes how it ensures the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members.	1	Met
4.	CCO analyzes wait times for appointments with providers, including specialists.	0.5	**Findings:** YCCO described how its dental delegate tracks, analyzes, and monitors wait times for oral health services; however, the CCO provided a minimal description of how it analyzes wait times for appointments with physical and mental health providers and specialists. YCCO submitted its Availability of Service (SVC-001) policy and procedure as supporting documentation; however, the document did not describe the how wait times are analyzed. **Recommendation for the Next Submission:** YCCO should provide a narrative describing how wait times for appointments with providers, including specialists, are analyzed.
5.	CCO discusses how the network ensures time and distance standards for member access to specialists. CCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment providers, dental care providers, and availability of acute care beds. CCO addresses ratios for pediatric, adult, and geriatric providers. The CCO should analyze these ratios and describe whether the CCO considers these ratios adequate.	1	Met

Indicator		Score	Findings/Recommendations
7.	CCO describes how traditional health care workers (by type) are incorporated into the delivery network. The CCO should analyze and describe by type whether the CCO considers this adequate.	1	Met
8.	CCO describes how non-emergency transportation is provided across the delivery network. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should analyze and describe whether the CCO considers this adequate.	1	Met
10.	CCO demonstrates a continuum of care (adults/children, crisis, outpatient, intensive outpatient [e.g., Assertive Community Treatment (ACT), Dialectic Behavioral Therapy (DBT), Intensive Community-Based Treatment Services (ICTS)], residential, inpatient) for treatment of mental health disorders. The CCO should analyze and describe whether the CCO considers this adequate.	0.5	**Findings:** YCCO described its analysis of behavioral services and the coordination of services not available through its delivery network; however, the CCO did not demonstrate the continuum of care for the treatment of mental health disorders (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient). **Recommendation for the Next Submission:** YCCO should provide a narrative that demonstrates a continuum of care for the treatment of mental health disorders (adults/children, crisis, outpatient, intensive outpatient [e.g., ACT, DBT, ICTS], residential, inpatient).
11.	CCO demonstrates a continuum of care (adult/child, detox, outpatient, intensive outpatient, residential) for treatment of substance use disorders. The CCO should analyze and describe whether the CCO considers this adequate.	0.0	**Findings:** YCCO's description did not demonstrate a continuum of care for the treatment of SUDs (adult/child, detox, outpatient, intensive outpatient, residential). In addition, the CCO did not include analysis or describe whether the CCO considers the available continuum of care to be adequate. **Recommendation for the Next Submission:** YCCO should provide a narrative that demonstrates a continuum of care for the treatment of SUDs (adult/child, detox, outpatient, intensive outpatient, residential). The CCO should also provide analysis and describe whether the available services are considered adequate.

Indicator		Score	Findings/Recommendations
12.	CCO describes network availability/adequacy and use of alternative therapies (e.g., acupuncture, chiropractic, physical therapy, massage, yoga) to meet the needs of members.	1	Met
	Total Score	**10.0**	**Out of Possible 12.0**
Description of Members			
13.	CCO describes its process for taking into account member characteristics when making provider assignments. • CCO provides analysis of the language and cultural needs of members. • CCO provides analysis of the needs of members with disabilities and members with special health care needs.	1	Met
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	1	Met
15.	CCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
	Total Score	**3.0**	**Out of Possible 3.0**
Additional Analysis of the CCO's Provider Network to Meet Member Needs			
16.	CCO describes how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, adult (MHSIP), family (YSS-F), and child (YSS) mental health survey, and CAHPS. The CCO needs to describe how it uses the input from its community advisory council.	1	Met
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
18.	CCO describes procedures to ensure that members with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that members may take to promote their own health.	1	Met

Indicator		Score	Findings/Recommendations
19.	CCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The CCO should address all levels within the organization, including leadership and provider network.	1	Met
	Total Score	**4.0**	**Out of Possible 4.0**
Coordination of Care			
20.	CCO describes relationship (including any memoranda of understanding) with: • Aging and Persons with Disabilities • Local public health authority • Local mental health authority • IHS and/or Tribal Health Clinics	1	Met
21.	CCO discusses coordination with above stakeholders.	1	Met
22.	CCO discusses how interdisciplinary care teams are used to coordinate services across the continuum of care. The CCO analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.	1	Met
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met
24.	CCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all members across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**
Performance on Metrics			
25.	CCO describes its efforts to build network capacity for those metrics where the CCO's performance is below the baseline.	1	Met

Indicator		Score	Findings/Recommendations
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 2.0**

Appendix B. CCO Plan Names

Acronym	CCO Plan Name
AH	Advanced Health
AllCare	AllCare CCO, Inc
CHA	Cascade Health Alliance, LLC
CPCCO	Columbia Pacific CCO
EOCCO	Eastern Oregon CCO
HSO	Health Share of Oregon
IHN CCO	InterCommunity Health Network CCO
JCC	Jackson Care Connect
PSCS-CO	PacificSource Community Solutions–Central Oregon
PSCS-CG	PacificSource Community Solutions–Columbia Gorge
PH	PrimaryHealth
TCHP	Trillium Community Health Plan, Inc.
UHA	Umpqua Health Alliance, LLC
WVCH	Willamette Valley Community Health, LLC
YCCO	Yamhill Community Care Organization