Oregon Health Authority
Health Services Division

2020 Delivery System Network Evaluation of Oregon Coordinated Care Organizations

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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 health care 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) contracts with 15 coordinated care organizations (CCOs) to deliver managed care services for Oregon Health Plan (OHP) Medicaid members in the State. Each organization is contractually required to develop and submit a Delivery System Network (DSN) Report that consists of two components, a DSN Provider Narrative Report and a DSN Provider Capacity Report, which crosswalk to the network standards in the OHA 2020 Health Plan Services CCO 2.0 Contract, Exhibit G(2)(a). While each CCO was originally scheduled to submit a quarterly DSN Provider Narrative Report and DSN Provider Capacity Report, OHA reduced the frequency of the DSN Provider Narrative Report submission to annually. In 2020, OHA amended submission deadlines in response to the coronavirus disease 2019 (COVID-19) pandemic. In April 2020, OHA communicated the CCOs are required to submit an annual DSN Provider Narrative Report and an initial Targeted DSN Provider Capacity Report Review on or before September 1, 2020, with subsequent submissions scheduled for the third and fourth quarters of 2020.

Health Services Advisory Group, Inc. (HSAG), the State's contracted external quality review organization (EQRO), developed detailed *2020 CCO Annual DSN Provider Narrative Report Instructions*, *2020 Quarterly DSN Provider Capacity Report Instructions*, and templates, which include specifications that aim to capture better data and incorporate more of the intent of the 2020 CCO contracts, including provider workforce reporting components. Due to the difference in data collection tools and processes, as well as the implementation of network-based reporting metrics, HSAG conducted a technical assistance webinar on July 9, 2020. The webinar consisted of an overview of the 2020 DSN and Network Adequacy activities, reporting responsibilities, deliverable submission expectations, DSN evaluation key measures and scoring, and questions and answers.

OHA requested HSAG provide a comprehensive evaluation of the 2020 CCO DSN report, including findings regarding provider capacity compliance in accordance with standards for access to care and network adequacy to provide timely covered services to all members, and strengths and gaps regarding the DSN. Overall findings from the evaluation, individual CCO results, and recommendations to the State are included in this 2020 CCO DSN Evaluation Report.

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

2020 CCO DSN Evaluation Report Objective

Based on the requirements outlined in the OHA 2020 Health Plan Services CCO 2.0 Contract, Exhibit G(2)(a), HSAG developed the 2020 CCO DSN Evaluation Report to provide OHA with an annual evaluation of CCO network compliance with established network standards and timely access to care and services requirements. The 2020 CCO DSN Evaluation Report includes:

a. A comprehensive summary of evaluation results, including general assessments.
b. Findings and required actions for each CCO to achieve OHA network adequacy standards.
c. Overarching recommendations to OHA, including any need for technical assistance or clarification regarding OHA requirements.

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 and submit comprehensive narrative responses and analysis demonstrating how the CCOs ensure, monitor, and evaluate adequate provider capacity, including geographic location of network providers and members, considering distance, travel time, member needs, coordination of care, and performance metrics. CCOs must, at a minimum, incorporate the provided specifications into their comprehensive written responses and supplemental documentation (e.g., policies, procedures, manuals, analytics, etc.) and demonstrate how the DSN is monitored to ensure adequate provider capacity and member access.

If any component of a CCO's DSN is subcontracted or delegated, the CCO must also include a narrative response and supplemental documentation (e.g., policies, procedures, manuals, analytics, etc.), including three OHA-defined time and distance standards for each geographic classification in its service area, describing how delegated services are integrated with the CCO's overall DSN, and how the CCO monitors its delegated providers, ensuring compliance with federal and State provider network requirements. Table 1-1 identifies the five DSN Provider Narrative Report categories, the number of reporting elements associated with each category, and the maximum number of points possible for scoring the CCOs' compliance with the elements.

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 Time and Distance Report

The DSN Provider Narrative Report additionally requires each CCO to document its compliance with OHA's travel time and distance standards pursuant to OAR 410-141-3515. CCOs demonstrated compliance by reporting the time and distance standards of minutes and miles of overall member access for each geographic classification in its service area, as listed in Table 1-2 below. CCOs used the precise location of the closest participating DSN provider and the member's address to calculate the CCO's time (minutes) and distance (miles) standards. CCOs calculated member travel time and distance based on the provider types identified in the *2020 CCO Annual DSN Provider Narrative Report Instructions*.

Table 1-2—DSN Time and Distance Standards

Geographic Classification	Definition	Time Standard	Distance Standard	Percentage of Member Access
Urban	A geographic area that is less than 10 map miles from a population center of 30,000 people or more.	30 Minutes	30 Miles	90 Percent (%)
Rural	A geographic area that is 10 or more map miles from a population center of less than 30,000 people.	60 Minutes	60 Miles	90 Percent (%)

Quarterly DSN Provider Capacity Report

CCOs submit a DSN Provider Capacity Report, which is an inventory of the CCOs' providers and facilities, using a DSN Provider Capacity Report Template provided by OHA. All participating providers, either employed directly or through subcontract with a CCO and providing services to Medicaid members, were included. Required data elements of the report are outlined in the OHA 2020 Health Plan Services CCO 2.0 Contract, Exhibit G(2)(a).

All providers, facilities, or businesses must be identified with the accurate corresponding DSN provider capacity field values. A complete list of the value set, provider category, and associated service category values and descriptions can be viewed in the *2020 Quarterly DSN Provider Capacity Report Instructions*.

HSAG developed templates and detailed *2020 Quarterly DSN Provider Capacity Report Instructions* that include specifications aimed to improve data consistency and quality. The instructions outline the data submission requirements and include the specifications for defining the data extraction used to submit the provider files. Participating providers and facilities are categorized using the provider categories and service categories, as identified in Appendix A. Failure to submit the initial DSN Provider Capacity Report according to the instructions may result in the rejection of the CCO's report submission and lead to required resubmission.

HSAG processed, cleaned, and evaluated the data to assess the general capacity of each CCO's compliance with the required provider file layout as outlined in the *2020 Quarterly DSN Provider Capacity Report Instructions*. Specifically, HSAG evaluated each CCO's DSN Provider Capacity Report on four domains:

- Quality of DSN Provider Capacity Reporting.
- Provider Network Count.
- Provider Accessibility.
- Geographic Distribution.

A time and distance analysis, applying OHA-supplied member data, using the below key measures was conducted:

- Percentage of members living within the time/distance standards.
- Average time (in minutes) and distance (in miles) to the nearest three providers for each provider type evaluated (e.g., primary care providers [PCPs] and hospitals).

DSN Provider Narrative Report Evaluation and Scoring

HSAG evaluated 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 did not address the element.
0.5	*Partially Met*	Discussion addressed some, but not all, of the element.
1.0	*Met*	Discussion comprehensively addressed 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**

HSAG evaluated the time and distance reported in the DSN Provider Narrative Report to assess each CCO's ability to meet contract standards related to members' access to providers.[2-1] CCOs reported provider time and distance standards (i.e., minutes and miles of overall member access) for each geographic classification in its service area to determine compliance based on the three OHA-defined time and distance standards using the rating and scoring criteria defined below in Table 2-3. All element scores were then aggregated into category scores and an overall summary score.

[2-1] Contract standards are detailed in OAR 410-141-3220, available online at: https://www.oregon.gov/oha/HSD/OHP/Policies/141rb011118.pdf.

Table 2-3—DSN Provider Narrative Report—Time and Distance Standards Scoring Criteria

Score	Rating	Rating Description
0.0	*Not Met*	Submission did not include any time and distance reporting.
0.5	*Partially Met*	Submission included one, but not all, time and distance reporting standards.
		Submission included all time and distance reporting but did not meet all OHA-defined time and distance standards.
1	*Met*	Submission included all time and distance reporting and met all OHA-defined time and distance standards.

DSN Provider Capacity Report Evaluation and Scoring

A one-time initial targeted review of the CCOs' DSN Provider Capacity Report submissions from September 1, 2020, was conducted by HSAG. The targeted review focused on the quality (e.g., percent present, valid field formats, and valid values) of each CCO's DSN Provider Capacity Report and a limited number of DSN data elements collaboratively identified by OHA and HSAG. OHA was provided with a focused verification of each CCO's ability to comply with the initial quarterly DSN submission requirements. Initial target review results were communicated to the CCOs and should inform future DSN Provider Capacity Report submissions. The subsequent quarterly DSN Provider Capacity Report submissions must be compiled following the template and instructions, as failure to do so may result in the rejection of the CCO's report submission and lead to required resubmission.

Using the CCOs' October 2020 DSN Provider Capacity Report submissions, HSAG conducted data analysis to evaluate four domains, including the key measures identified below in Table 2-4.

Table 2-4—DSN Provider Capacity Report Domains and Key Measures

Domain	Description	Key Measures
Quality of DSN Provider Capacity Reporting	The CCO's ability to provide complete and accurate provider network data in the required format.	• Percent Present—The percent of key data fields that are populated. • Percent Valid Format—The percent of key fields where data are submitted in the required format (e.g., date elements are populated with formatted dates). • Percent Valid Values—The percent of key data fields containing allowable data values.
Provider Network Count	The underlying infrastructure of the CCO's DSN, including whether or not health services are available to members through a sufficient supply and variety of providers.	• Provider Counts—The number and percent of providers by key stratifications (e.g., provider specialty/category, pediatric/adult provider, panel status, network status, and contract status).

Domain	Description	Key Measures
Provider Accessibility	The degree to which contracted services are accessible to the CCO's member populations.	• Percent Accepting New Patients—The number and percent of providers accepting new patients by key stratifications (e.g., provider specialty/category, county, network status, and contract status). • Percent Non-English Language—The number and percent of providers that support non-English languages by key stratifications (e.g., provider specialty/category, county, network status, and contract status).
Geographic Distribution	The geographic distribution of providers relative to member beneficiary populations, assessing whether not the location of providers is spread proportionately across the member population.	• Provider Count by Geography—The number and percent of providers by county (or ZIP Code) by provider specialty/category. • Provider Coverage Maps—A visual presentation of coverage area provided by each CCO's DSN based on pre-defined time and distance thresholds, by provider specialty/category.

Overall DSN Provider Narrative Report Evaluation Results

Overall, the CCOs received a score of 22.9 points across aggregated DSN Provider Narrative Report categories, or approximately 88.1 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, two CCOs struggled to meet the possible points across all narrative categories.

The majority of CCOs incorporated the required response specifications outlined in the *2020 Annual CCO DSN Provider Narrative Instructions* in their narrative responses. The responses and analysis improved from previous years and included more comprehensive descriptions demonstrating how the CCOs ensured, monitored, and evaluated adequate provider capacity and member access to health care services, including geographic location of network providers and members, considering distance, travel time, member needs, coordination of care, and performance metrics.

Table 3-1—DSN Provider Narrative Report Evaluation 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	3.0	3.5	4.5	2.0	21.0
CHA	5.0	1.5	3.5	5.0	0.5	15.5
CPCCO	12.0	3.0	4.0	5.0	2.0	26.0
EOCCO	10.0	3.0	4.0	5.0	2.0	24.0
Health Share	11.0	3.0	4.0	5.0	2.0	25.0
IHN	10.0	2.5	3.0	4.0	2.0	21.5
JCC	12.0	3.0	4.0	5.0	2.0	26.0
PSCS-CO	11.0	3.0	4.0	5.0	2.0	25.0
PSCS-CG	11.0	3.0	4.0	5.0	2.0	25.0
PSCS-Lane	11.0	3.0	4.0	5.0	2.0	25.0
PSCS-MP	11.0	3.0	4.0	5.0	2.0	25.0
TCHP	11.0	2.5	3.5	4.5	1.5	23.0
UHA	7.5	2.0	3.5	3.5	2.0	18.5

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	
YCCO	7.5	2.0	3.0	3.5	1.5	17.5
Statewide Average Scores	**10.0**	**2.7**	**3.7**	**4.7**	**1.8**	**22.9**
Points Possible	**12.0**	**3.0**	**4.0**	**5.0**	**2.0**	**26.0**

* Please see Appendix C 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 (BH), 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 member access to non-emergent medical transportation (NEMT), transportation and access for members with disabilities or special health care needs, demonstration of the continuum of care for treatment of mental health (MH) disorders and treatment of substance use disorders (SUDs), and a description of network availability/adequacy and use of alternative therapies to meet the needs of members.

CCO Results

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

The majority of CCOs included the required geographic distribution description and analysis for all providers (including delegated providers) compared to the distribution of members. Thirteen of the 15 CCOs described using a geocoding software to conduct geographic distribution analysis, including time and distance standards. Ten of the 13 CCOs reported using Quest Analytics, while the other three CCOs used a combination of SQL, Tableau, and Google Geocoding and Distance Matrix Application Programming Interface (API). The remaining two CCOs did not specify which geocoding application or software was used to conduct analysis.

Even though the Annual DSN Provider Narrative Instructions outlined specifications for calculating time and distance standards, there were still inconsistencies with the 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.

Thirteen of the 15 CCO's narrative responses described how traditional health workers (THWs) are incorporated into the DSN by type and analyzed whether the CCO considers member access to these services as adequate. For example, one CCO established a THW Advisory Committee composed of community-based organizations and agencies that provides peer-run supports, member advocacy and educations, patient health navigation with representation from community health workers (CHWs), doulas, public health programs, subcontracted providers, organizations, and agencies that have established programs with employed THWs. During 2020, the THW Advisory Committee defined the methodology to capture THW baseline utilization and performance data over time; this included identifying metrics to demonstrate return on investment, including but not limited to, implementing mechanisms to track member satisfaction with THW services, requiring reporting of THW activities with grant-funded contracts, and tracking THW claims data and EHR reports to capture fee-for-service (FFS)-reimbursed THW encounters.

Conclusions

Drawing on the narrative responses, HSAG concluded that there continue to be opportunities for improvement for CCOs to integrate OHA network adequacy contractual requirements and analyses into their ongoing monitoring activities to ensure member access to covered services within their DSN system. The time and distance calculation process may require a better defined methodology and additional technical assistance on mechanisms to 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 DSN. Standardization of reporting by all CCOs would further support both the CCOs' and OHA's oversight of DSNs, as described in OAR 410-141-3220.

Recommendations

Based on the conclusions presented above, HSAG upholds two of the three recommendations from the 2019 DSN Evaluation Report and included two new recommendations. The CCOs should:

- Continue designing and implementing ongoing monitoring mechanisms and strategies to track and evaluate members' access to care, including compliance with time and distance standards (2019 recommendation).
- 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), BH, and dental providers (2019 recommendation).

- Continue designing and implementing strategies to measure routine time and distance standards (30 and/or 60 miles and minutes) 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 health care within each CCO's DSN (2020 recommendation).
- Follow all specifications outlined in the Annual DSN Provider Narrative Instructions, including complete and comprehensive narrative responses and all required analysis for the corresponding elements in this category(2020 recommendation).

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, and disability needs as well as special health care needs 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

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

With regard to CCOs describing the processes for taking into account member characteristics when making provider assignments, the majority of CCOs had some mechanism for analyzing the characteristics of its members to ensure that the cultural, language, disability, and special health care needs are met. Eleven of 15 CCOs described processes for taking into account member characteristics when making provider assignments and included analysis, demonstrating the categorization of members by characteristics for the purpose of ensuring that the assigned PCP can best address each member's needs. Two of the 15 CCOs described different tools and data sources used to identify member characteristics and needs; however, the narrative responses did not specifically address processes and/or procedures for conducting analysis. Three of 15 CCOs also did not submit analysis to demonstrate the characteristics of its membership's cultural, language, disability, and special health care needs were incorporated in the narrative responses or as supplemental data.

All 15 CCOs described how member needs for continuity of care and transition between levels of care are assessed by conducting a needs assessment to identify risks and/or determine each member's appropriate level of care at the time of the transition. Upon notification of an inpatient admission, one CCO's utilization management (UM) team initiates contact with the facility's utilization team to start and continue its assessment of the member's level of care and needs throughout the member's length of stay. Prior to discharge, the CCO's UM and care management (CM) staff also meet regularly to discuss inpatient admissions, member's pre- and post-transition assessment, and address any barriers to care, ensuring that members receive the correct level of care and follow-up in the most appropriate setting. As for members discharged back home, they receive a follow-up from a transition of care (TOC) program

care manager within two business days of being home. The CCO makes two telephonic attempts and then sends a letter to the member, notifying him or her about the TOC program. If the member agrees to enroll in the voluntary program, the care manager assesses the member's understanding with regard to his or her discharge plan; scheduling follow-up appointments; coordinating access to medications prescribed; durable medical equipment (DME); NEMT services; other stakeholder services; and promoting medication adherence as well as self-care training and management.

Conclusions

Evaluation results indicated that the CCOs should conduct more comprehensive analyses of the cultural, language, disability, special health care, 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 the two recommendations from the 2019 DSN Evaluation Report and included one new recommendation that the CCOs:

- Continue developing and implementing processes to ensure the collection of supplemental member data (e.g., cultural, language, disability, special health care, and diagnosis-related needs) to support the monitoring and reporting of member needs (2019 recommendation).
- Continue developing reports and internal metrics for assessing the adequacy of the CCOs' DSN relative to key member characteristics (2019 recommendation).
- Follow all specifications outlined in the Annual DSN Provider Narrative Instructions, including complete and comprehensive narrative responses and all required analysis for the corresponding elements in this category (2020 recommendation).

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, MH 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 special 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

Nine 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.

Six of the 15 CCOs did not meet the first element of this category that required CCOs to incorporate member feedback into network adequacy decisions. Two of the six CCOs address how they incorporated member feedback obtained from MH surveys, complaints and grievances, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3-3] survey results; however, neither incorporated an example or scenario demonstrating how member feedback from surveys impacted a network adequacy decision. Three of the six CCOs reported they had an established CAC; however, two of three did not describe a process and/or procedure for how input from CAC was used to support and influence network adequacy and/or network capacity, and none of the three CCOs incorporated an example or scenario demonstrating how CAC input impacted a network adequacy decision. 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.

All 15 CCOs described how technology is used to deliver team-based care and support other innovations. All CCOs expanded access to telehealth and telemedicine services in alignment with the directive and guidelines set by the Health Systems Division (HSD) and the Centers for Medicare & Medicaid Services (CMS) in response to the COVID-19 pandemic. One CCO created a page on its website for provider-related COVID-19 updates, including a large section dedicated to telehealth and telemedicine resources, including technical assistance guides for physical, behavioral, and oral health services; billing codes; webinars; frequently asked questions; and other notifications and materials from OHA, CMS, and the Department of Health and Human Services (HHS). The CCO also partnered with an e-Consultation vendor to provide PCPs with timely access to clinical expertise in over 100 specialties and sub-specialties nationwide. PCPs receive unbiased opinions to validate if a patient would benefit from seeing a specialist face to face or might require further diagnostics and treatment options that can be provided in the PCP office. This available resource helped reduce inappropriate referrals, improved member access to specialty care, and contributed to better overall member care and care planning.

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., MH 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

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

regularly convene CACs as required by Oregon Revised Statute (ORS) 414.627, feedback from council meetings is not being incorporated into network adequacy decisions.

Recommendations

Based on the conclusions presented above, HSAG upholds two of three recommendations from the 2019 DSN Evaluation Report and included one new recommendation that the CCOs:

- Continue developing mechanisms to collect member feedback from existing data sources (e.g., member and health care surveys, complaints and grievances, CAC, etc.) and incorporate the information into network adequacy analyses to support network management decisions (2019 recommendation).
- 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 (2019 recommendation).
- Follow all specifications outlined in the Annual DSN Provider Narrative Instructions, including complete and comprehensive narrative responses and all required analysis for the corresponding elements in this category (2020 recommendation).

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 special health care needs and coordinate services across the continuum of care to reduce hospital readmission, emergency room use, and access to preventive health care.

CCO Results

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

The majority of the CCO narratives provided descriptions of their contractual relationships with local Aging and Persons with Disabilities (APD) offices, public health authorities, and MH authorities that facilitate the coordination of care.

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 an integrated approach across the spectrum of physical, mental, and oral health care.

The majority of 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 health care, including preventive health

care, for all members across the continuum of care. Multiple CCOs described using the Collective Platform, also known as Pre-Manage, a medical platform tool, to share real-time hospital/emergency department (ED) event information; member-level data and preventive gaps in care; and member-specific information for the purpose of coordinating physical, dental, and behavioral health care between provider offices, hospitals, and community partners. For example, various CCOs explained leveraging real-time notifications to identify members needs and proactively coordinate care and offering members additional support post-ED visits and coordination of care prior to hospital discharges.

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 an integrated approach across the spectrum of physical, mental, and oral health care. One CCO identified a member that utilized the ED nine times and had one inpatient stay over a 12-month period as a result of chronic pain and opioid dependence among other chronic health conditions. The CCO's CM team worked with the member to find the appropriate specialist to treat the root cause of their chronic conditions (vascular surgeon, neurology, and pain management), and the member began attending routine follow-up care for their complex conditions. On account of the inter-disciplinary meetings with the member's providers and a CHW, the team determined that the member would benefit from continuous CM support during off weeks when the member did not meet with their CHW. The constant case management improved ongoing care received by the member, approved DME to support the member (bathtub transfer bench and bath chair), worked directly with APD to ensure the member had enough caregiver hours available to meet their needs, and furnished Meals on Wheels and a weekly food box to them every week. As a direct result, the member was engaged, consistently attended provider follow-up appointments, received BH treatment, and ultimately eliminated ED and inpatient utilization.

Conclusions

Evaluation results indicated that each CCO has established relationships with local APD offices, public health authorities, and MH authorities that facilitate the coordination of member services across the continuum of care. Overall, the CCO responses demonstrated that their interdisciplinary care teams' 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 special health care needs, level of complexity, and location.

Recommendations

Based on the conclusions presented above, HSAG upholds two of the three recommendations from the 2019 DSN Evaluation Report and included one new recommendation that the CCOs:

- Continue expansion of internal processes and operational mechanisms to facilitate a care coordination approach that integrates physical health, BH, and dental health services and supports (2019 recommendation).
- 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 health care needs, especially for members with special health care needs (2019 recommendation).

- Follow all Annual DSN Provider Narrative Instructions specifications, including complete and comprehensive narrative responses and all required analysis for each element in this category (2020 recommendation).

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

Twelve 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 DSN. Several CCOs have developed or invested in population management software and tools to create actionable and visual data reports, which are distributed to providers and/or individual offices in an effort to improve performance on metrics related to member access and ED utilization.

For instance, one CCO's population utilization and enterprise data warehouse platform incorporated member demographics and special health care needs, physical, behavioral, and oral health claims; pharmacy data; and known member chronic conditions to predict member risk stratification, project support CM function, understand patterns of member access, and identify gaps in preventive care. The CCO regularly met with its subcontractors and partners to monitor performance on metrics and identify strategies for improving network capacity, aligning interventions, and establishing a best practice approach to overall improvement. The CCO distributed regular member-level data reports specifying which members(s) were included in the denominator for each metric, which vaccines each member received, which vaccinations the member needed, and whether the member met numerator criteria according to data from OHA's ALERT immunization information system registry as an effort to address performing below the baseline on childhood immunizations. This type of delineated data providers partners more clarity as to where their efforts should be focused.

A 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 (CAPs), alternative payment models (APMs), disease-specific case management programs, and member education as some of the actions taken to address patterns of both overutilization and underutilization. One CCO had a special task force comprised of leadership staff to review and analyze trends in health care costs across all product lines and develop actionable items to reduce costs and bring the Medical Loss Ratio to sustainable levels. A review of quarterly cost and utilization identified a spike in ED costs

related to frequently high intensity evaluation and management codes at local hospitals. To demonstrate the action taken, the CCO hired an outside auditor to perform an audit on the ED billing, resulting in higher cost billing that looked to represent submission of codes for more serious (and more expensive) diagnoses or procedures than the provider actually diagnosed or performed. The CCO presented the findings to two large hospitals and implemented CAPs to address the improper billing.

Conclusions

Overall, the CCOs described their processes for monitoring performance metrics internally and across their DSNs. 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 2019 DSN Evaluation Report and included one new recommendation that the CCOs:

- Continue internal monitoring of CCO performance on quality measures and implement appropriate changes to its DSN to support measure improvement (2019 recommendation).
- Continue to track and analyze overutilization and underutilization patterns and develop mechanisms to address and correct identified patterns (2019 recommendation).
- Submit complete and comprehensive narrative responses that address all DSN Provider Narrative Instructions specifications and submit all required analysis for each element in this category (2020 recommendation).

Time and Distance Standards Reporting

Overall, the CCOs received a score of 13.2 points across aggregated DSN Provider Narrative Report—Time and Distance Standards, or approximately 94.3 percent of the maximum points possible (14.0 points), as shown in Table 3-2 below.

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

CCO Name*	DSN Provider Narrative Report—Time and Distance Standards**														Total CCO Score
	PCPA	PCPP	PCPCH	OBGYN	MHPA	MHPP	SUDPA	SUDPP	HOSP	RX	OHPA	OHPP	SPA	SPP	
AH	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
AllCare	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
CHA	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
CPCCO	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
EOCCO	1	0.5	1	1	1	1	1	1	1	1	1	1	1	1	13.5
Health Share	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
IHN	1	1	1	0	1	1	1	1	1	0	0	0	1	1	10.0
JCC	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
PSCS-CO	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
PSCS-CG	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
PSCS-Lane	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
PSCS-MP	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
TCHP	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
UHA	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	7.0
YCCO	1	0.5	1	1	1	1	1	1	1	1	1	1	1	1	13.5
Statewide Average Scores	**1.0**	**0.9**	**1.0**	**0.9**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**0.9**	**0.9**	**0.9**	**1.0**	**1.0**	**13.2**
Points Possible	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**14.0**

* Please see Appendix C for a list of full CCO names.
**Please see Appendix A for a list of service category descriptions for the DSN provider capacity field values.

CCO Results

As a result of the guidance provided, the CCOs demonstrated DSN time and distance compliance by reporting the time and distance standards of minutes, miles, and percent of overall member access for each geographic classification in its service area distance; this section was scored solely based on the CCOs' ability to report values within the standard for their geographic classification for all required service categories.

Twelve of the 15 CCOs met all of the elements in the *Time and Distance Standards Reporting* section of the narrative. The CCOs reported their access standards compliance in either routine time or distance (i.e., minutes and miles) and with the percentage of members in the service area that can access health care 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.

Six of the 12 CCOs reported their routine time or distance standard as 30 and/or 60 miles and minutes across every service category without any variation; however, the CCOs reported variations in percentages to demonstrate calculations of members with access in their service areas. Five of the 12 CCOs provided detailed time and distance standards with variations in minutes, miles, and percentages, demonstrating the CCOs calculated member travel time and distance, and percentage of members with access in their service area. The remaining CCO reported its routine time and distance as the standard 30 and 60 miles and minutes, and 90 percent of members with access in their service area with no variation, across all service categories.

Of the remaining three, one CCO only reported the percentage of members with access in its service area with no variation, across all service categories. Another CCO reported its routine time or distance standard as 30 and/or 60 miles and minutes across every service category without any variation, and variations in percentages to demonstrate calculations of members with access in their service area; however, the CCO was not in compliance with the 73.40 percent of pediatric members having access to Primary Care Provider, Pediatric (PCPP). The remaining CCO reported detailed time and distance standards with variations in minutes, miles, and percentages, demonstrating the CCO's calculated member travel time and distance, and percentage of members with access in their service area; however, the CCO did not report standards for Obstetrics/Gynecology (OB/GYN), Pharmacies (RX), Oral Health Provider, Adult (OHPA), and Oral Health Provider, Pediatric (OHPP).

Conclusions

Evaluation results indicated that the CCOs did not make a concerted effort to calculate and report time (minutes), distance (miles), and overall member access (percent) time and distance standards, instead reporting values that mirrored the standard with no variation. 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 DSN. Standardization of reporting by all CCOs would further support both the CCOs' and OHA's oversight of DSNs.

Recommendations

Based on the conclusions presented above, HSAG upholds all three recommendations from the 2019 DSN Evaluation Report:

- 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, OB/GYN, MH/BH, SUD, Hospital, Pharmacy, Dental, and Specialist) within the CCOs' DSN, ensuring compliance with the OHA standard (2019 recommendation).
- 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 MH, mental health/SUD, and dental providers.) (2019 recommendation).
- 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 health care within the CCO's DSN. Reporting methodology and values should not differ from the time and distance standards reported for the relevant *Description of the DSN and Adequacy* category elements (2019 recommendation).

Overall DSN Provider Capacity Report Analysis Results

Quality of DSN Provider Capacity Reporting

HSAG's assessment of the third quarter DSN Provider Capacity Reports illustrated a majority of the CCOs rectified quality, consistency, and accuracy issues identified during the one-time Targeted DSN Provider Capacity Report Review, resulting in improved data elements, data field format/value, and data file layout validity and alignment with the specifications in the *2020 Quarterly DSN Provider Capacity Report Instructions*. Below are the observed reporting exceptions:

- Two of the 15 CCOs submitted a DSN Provider Capacity Report that did not remedy key quality reporting issues identified in the one-time Targeted DSN Provider Capacity Report Review. Two CCOs submitted data records with invalid values populated in the Provider Service Category data fields (e.g., DSPA, DSPP, MMPA). One of the two CCOs resubmitted a DSN Provider Capacity Report with no data records identified as the Provider Category Description of Facility "04" or Business or Healthcare Services "05."
- One of the 15 CCO's DSN Provider Capacity Report interchanged two data fields, reporting values for "# of Members Assigned to PCP" in the "Accepting New Medicaid Members" data field.

Provider Network Count

HSAG processed, cleaned, deduplicated, and assessed each CCO's third quarter DSN Provider Capacity Report, identifying the number and percent of individual practitioners, facilities, businesses, and services by key stratifications (e.g., provider/service category, pediatric/adult provider, panel status, network status, contract status, and geographic distribution).

- One of the 15 CCOs submitted its DSN Provider Capacity Report with no data records identifying the Provider Category Description of Facility "04" or Business or Healthcare Services "05."
- After deduplication by NPI, two of the 15 CCOs were assessed as having no contracted and in-network SUD practitioners rendering care to pediatric members.
- None of the 15 CCOs submitted DSN Provider Capacity Reports with populated data records for all nine individual practitioner service categories.

Provider Accessibility

HSAG assessed CCO provider accessibility, identifying the total number of PCPs (e.g., PCPA, PCPP, and PCPCH) accepting new members. Table 3-3 exhibits data results stratified by contracted, in-network providers and contracted, out-of-network providers.

- One CCO's DSN Provider Capacity Report interchanged two data fields, reporting values for "# of Members Assigned to PCP" in the "Accepting New Medicaid Members" data field, resulting in no PCPs accepting new members.
- Seven of the 15 CCOs were assessed with greater than 80 percent of the total number of contracted, in-network PCPs accepting new members.
- Eight of the 15 CCOs were assessed with less than 70 percent of the total number of contracted, in-network PCPs accepting new members.
- Six of the 15 CCOs demonstrated wide-spread access to contracted, out-of-network PCPs accepting new members.

Table 3-3—Number and Percent of PCPs Accepting New Patients, by CCO

	All Providers			Contracted, In-Network Providers			Contracted, Out-of-Network Providers		
CCO[1]	Number Accepting New Patients	Total Number of PCPs	Percent	Number Accepting New Patients	Total Number of PCPs	Percent	Number Accepting New Patients	Total Number of PCPs	Percent[2]
AH	89	89	100.0%	89	89	100.0%	0	0	—
AllCare	90	401	22.4%	90	401	22.4%	0	0	—
CHA	68	191	35.6%	68	139	48.9%	0	0	—
CPCCO	1,306	6,904	18.9%	135	349	38.7%	1,171	6,555	17.9%

	All Providers			Contracted, In-Network Providers			Contracted, Out-of-Network Providers		
CCO[1]	Number Accepting New Patients	Total Number of PCPs	Percent	Number Accepting New Patients	Total Number of PCPs	Percent	Number Accepting New Patients	Total Number of PCPs	Percent[2]
EOCOO	769	1,000	76.9%	283	289	97.9%	486	711	68.4%
Health Share	7,085	7,085	100.0%	5,388	5,388	100.0%	1,697	1,697	100.0%
IHN	267	278	96.0%	218	224	97.3%	49	54	90.7%
JCC	1,366	6,944	19.7%	185	682	27.1%	1,181	6,262	18.9%
PSCS-CO	199	286	69.6%	199	286	69.6%	0	0	0.0%
PSCS-CG	85	93	91.4%	85	93	91.4%	0	0	0.0%
PSCS-Lane	334	511	65.4%	334	493	67.7%	0	0	0.0%
PSCS-MP	302	437	69.1%	302	437	69.1%	0	0	0.0%
TCHP	360	360	100.0%	259	259	100.0%	101	101	100.0%
UHA	124	154	80.5%	124	154	80.5%	0	0	0.0%
YCCO	0	1,308	0.0%	0	1,308	0.0%	0	0	0.0%

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Geographic Distribution

The geographic distribution of providers relative to member populations assessed whether or not the individual practitioner and facility/business/service providers were spread proportionately across the beneficiary population. HSAG conducted access analysis using the provider service categories listed in the Time and Distance section of the DSN Provider Narrative Report.

- Seven of the 15 CCOs were assessed with no deficiencies, validating that at least 90 percent of both adult and pediatric members had sufficient access to all required provider service categories within each CCO's service area and corresponding ZIP Codes.
- Six of the 15 CCOs had a geographic distribution of PCPCH practitioners and facilities compared to their memberships that was not sufficient to cover each CCO's service area based on the OHA pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes). HSAG's analysis identified no PCPCH practitioners and facilities reported by each CCO, validating that 100 percent of all members were without access.
- Two of the 15 CCOs had a geographic distribution of PCPs compared to their memberships that were not sufficient to cover each CCO's service area based on the OHA pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes). Both CCOs were assessed as having less than 90 percent of adult and pediatric members with sufficient access to PCPA and PCPP services in both rural and urban areas.

- Three of the 15 CCOs had a geographic distribution of SUD providers, compared to their pediatric members, that was not sufficient to cover each CCO's service area based on the OHA pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes). HSAG's analysis identified no SUD providers reported by each CCO, validating that 100 percent of all members were without access.
- One of the 15 CCOs had a geographic distribution of SPPs compared to their pediatric members that was not sufficient to cover each CCO's service area based on the OHA pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes).
- All 15 CCOs were assessed to have membership residing in counties and ZIP Codes that did not align their assigned CCO's geographic service area.

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 42 CFR §438.206 and §438.207; the OHA 2020 Health Plan Services CCO 2.0 Contract, Exhibit G(2)(a); and OAR 410-141-3515.

Of the six 2019 DSN Evaluation Report proposed recommendations, five were approved and implemented as components of the *2020 CCO Annual DSN Provider Narrative Report Instructions*. The instructions outlined specifications for the corresponding elements in each category. At a minimum, CCOs were required to incorporate the specifications into their comprehensive written responses and demonstrate how the DSN is monitored to ensure adequate provider capacity and member access. Notably, the instructions addressed which elements required responses specific to physical, oral, and MH services; identified which elements required supplemental documentation (e.g., policies, procedures, manuals, analytics, etc.) to demonstrate monitoring and access within their DSNs; and established a standardized methodology for time and distance calculations. Although the instructions contained clear and straightforward guidance, several CCO narrative responses once again included varying levels of description, detail, evaluation, analysis, and independent methodologies used to conduct time and distance calculations.

HSAG upholds two of the 2019 DSN Evaluation Report recommendations and included two new recommendations that OHA make adjustments to the required Annual 2020 CCO DSN Provider Narrative Report Template to further minimize inconsistent interpretations of the elements and ambiguity around the appropriate type of supplemental documentation. Below are four 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 Annual 2020 CCO DSN Provider Narrative Report Template to ensure alignment with both the network adequacy standards established in accordance with 42 CFR §438.206 and §438.207; the OHA 2020 CCO 2.0 Health Plan Services Contract, Exhibit G(2)(a); and OAR 410-141-3515, creating clear and concise elements that describe what is required of the CCO (2019 recommendation).
- **Establish Standardized Time and Distance Standards:** OHA should reevaluate the time and distance standard elements outlined in the Annual 2020 CCO DSN Provider Narrative Report Template to ensure alignment with both the routine travel time and distance standards established in accordance with 42 CFR §438.206 and §438.207; the OHA 2020 CCO 2.0 Health Plan Services Contract, Exhibit G(2)(a); and OAR 410-141-3515, creating clear and concise elements that describe what is required of the CCO (2019 recommendation).
- **Define Urban and Rural Geographic Classifications:** OHA should reevaluate the definitions of "urban" and "rural" geographic area classifications in the DSN Provider Narrative template to ensure alignment with both the routine travel time and distance standards in accordance with 42 CFR

§438.206 and §438.207; the OHA 2020 CCO 2.0 Health Plan Services Contract, Exhibit G(2)(a); and OAR 410-141-3515, creating clear and concise elements that describe what is required of the CCO (2020 recommendation).

- **Eliminate Independent Time and Distance Standards Reporting:** OHA should reevaluate whether the independent time and distance standard reporting section incorporated in the Annual 2020 CCO DSN Provider Narrative Report Template can be eliminated. Instead, OHA should expand the time and distance standards reporting for the relevant *Description of the DSN and Adequacy* category elements to include PCPCH, OB/GYN, HOSP, and RX, eliminating duplicate efforts (2020 recommendation).

DSN Provider Capacity Report Recommendations

Of the seven 2019 DSN Provider Capacity Report recommendations, four were actualized and implemented. The *2020 Quarterly DSN Provider Capacity Report Instructions* were created and provide detailed guidance on proper completion of the report, establish submission expectations, standardize naming conventions, and construct a data dictionary that categorizes provider and specialty types. The DSN Provider Capacity Report provider file layout and instructions were developed to eliminate the reporting inconsistencies and establish CCO compliance expectations.

HSAG upholds four of the six 2019 DSN Provider Capacity Report recommendations and includes one new recommendation. In order to achieve consistent and accurate provider and facility inventories, historical Medicaid Management Information System (MMIS) codes and provider and service category values should be eliminated; OHA is adopting the Healthcare Provider Taxonomy Code Set to categorize the type, classification, and/or specialization of health care providers and facilities. Transformation and expansion of service categories will advance network-based reporting capabilities and metrics. Listed below are several recommendations for OHA to support more meaningful reporting of CCO provider network capacity.

- **Utilize the Standardized Healthcare Provider Taxonomy Code Set:** OHA should implement the adoption of the Healthcare Provider Taxonomy Code Set and eliminate the use of historical OHA 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 health care providers and facilities. All physicians and facilities are required to select the taxonomy code(s) that most closely describes the health care provider's type/classification/specialization when applying for a National Provider Identifier (NPI) (2019 recommendation).
- **Revise Standardized Provider File Layout (PFL) and Instructions:** OHA should implement a revised standardized PFL, accompanied by Provider Network Data Submission Instructions that reflect any revisions and/or updates. 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, MH, and dental health care providers),

program-specific definitions, standardized provider and facility type specifications, and a sample PFL template (2019 recommendation).

- **Conduct CCO Training on DSN Provider Capacity Reporting Changes:** OHA should conduct training for all CCOs and provide detailed guidance that reflects any revisions and/or updates on appropriate methods for submitting provider capacity information and review the requirements for submitting provider capacity network data (2019 recommendation).
- **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, provider directory validation, evaluation of appointment availability timeliness) (2019 recommendation).
- **Evaluate CCO Member Assignment:** OHA should evaluate members that appear to reside in counties and ZIP Codes outside of their assigned CCO's geographic service area (2020 recommendation).

Appendix A. CCO DSN Provider and Service Categories

Table A-1—DSN Provider Capacity Field Values—Provider Category

Provider Category Value	Provider Category Description
01	Individual Practitioner
02	Mid-level Practitioner
03	Other Practitioner
04	Facility
05	Business or Healthcare Services

Table A-2—DSN Provider Capacity Field Values—Service Category

Service Category Value	Service Category Description
PCPP	Primary Care Provider, Pediatric
PCPA	Primary Care Provider, Adult
SPP	Specialty Practitioner, Pediatric
SPA	Specialty Practitioner, Adult
OHPP	Oral Health Provider, Pediatric
OHPA	Oral Health Provider, Adult
MHPP	Mental Health Provider, Pediatric
MHPA	Mental Health Provider, Adult
SUDPP	Substance Use Disorder Provider, Pediatric
SUDPA	Substance Use Disorder Provider, Adult
QHCI	Certified or Qualified Health Care Interpreters
THW	Traditional Health Workers
HPSY	Hospital, Acute Psychiatric Care
EMT	Ambulance and Emergency Medical Transportation
CPS	Community Prevention Services
FQHC	Federally Qualified Health Centers
HPROMO	Health Education, Health Promotion, Health Literacy
HH	Home Health
Hospice	Hospice
HOSP	Hospital
Image	Imaging

Service Category Value	Service Category Description
IHS/THS	Indian Health Service and Tribal Health Services
MHCS	Mental Health Crisis Services
NEMT	Non-Emergent Medical Transportation
PC	Palliative Care
PCPCH	Patient Centered Primary Care Homes
RX	Pharmacies
DME	Durable Medical Providers
SNF	Post-hospital Skilled Nursing Facility
RHC	Rural Health Centers
SHC	School-based Health Centers
UCC	Urgent Care Center

Appendix B. DSN Evaluation and Analysis Results by CCO

Advanced Health

DSN Provider Narrative Evaluation Results

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

The CCO submitted a DSN Provider Narrative Report with comprehensive and detailed responses, accompanied with policies, desktop procedures, data dashboards, analytics and other supporting documentation to further demonstrate DSN-related monitoring and oversight mechanisms.

As a result of the COVID-19 pandemic, AH's Board of Directors authorized and created a Telehealth Access Fund to increase provider availability to technology and improve access to telehealth services. Project proposals were submitted by in-network providers and were reviewed by the CCO's Clinical Advisory Panel to determine the distribution of funds. AH awarded funds to 10 different provider organizations; 90 percent to providers in Coos County and the remaining 10 percent to Curry County providers. The funding was awarded to a diverse scope of provider specialty types; 41 percent to BH and SUD providers, 51 percent to PCPCH-recognized clinics, and the remaining 8 percent to other physical health providers and organizations. AH's narrative response also described using telemedicine services throughout its network in the form of real-time emergency room consultations for stroke, cardiology, and head trauma; consultations from specialty providers affiliated with North Bend Medical Center and Bay Area Hospital; and access to prescribing physicians for treatment of medication-assisted treatment for SUD to address provider shortages or issues of time and travel.

In addition to monitoring the utilization patterns of OHA incentivized and non-incentivized performance measures, AH also reported monitoring utilization trends identified while reviewing grievance and appeal system, medical management, and prior authorization data reporting. The CCO described how its analytics department used data from multiple sources and has developed a collection of strategies to address both under- and overutilization. AH submitted its 2020 Annual Transformation and Quality Strategy (TQS) Program document to describe program and project details, activities and interventions, and status reporting to demonstrate various actions taken to address member overutilization and underutilization. For example, AH implemented a collaborative project with its dental care organizations (DCOs) to improve the rate of diabetic members receiving oral health assessments. Some of the described interventions included, but were not limited to, creating a list to identify diabetic members with gaps in oral health care; developing a proactive workflow to schedule members; and creating standardized, targeted patient education materials related to oral health, and making them available in PCP settings.

Table B-1 provides the complete AH DSN Provider Narrative Report evaluation results.

Table B-1—AH—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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

Category Elements		Score	Findings/Recommendations
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	**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

Category Elements		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 surveys; and Consumer Assessment of Healthcare Providers and Systems (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**

Category Elements		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**

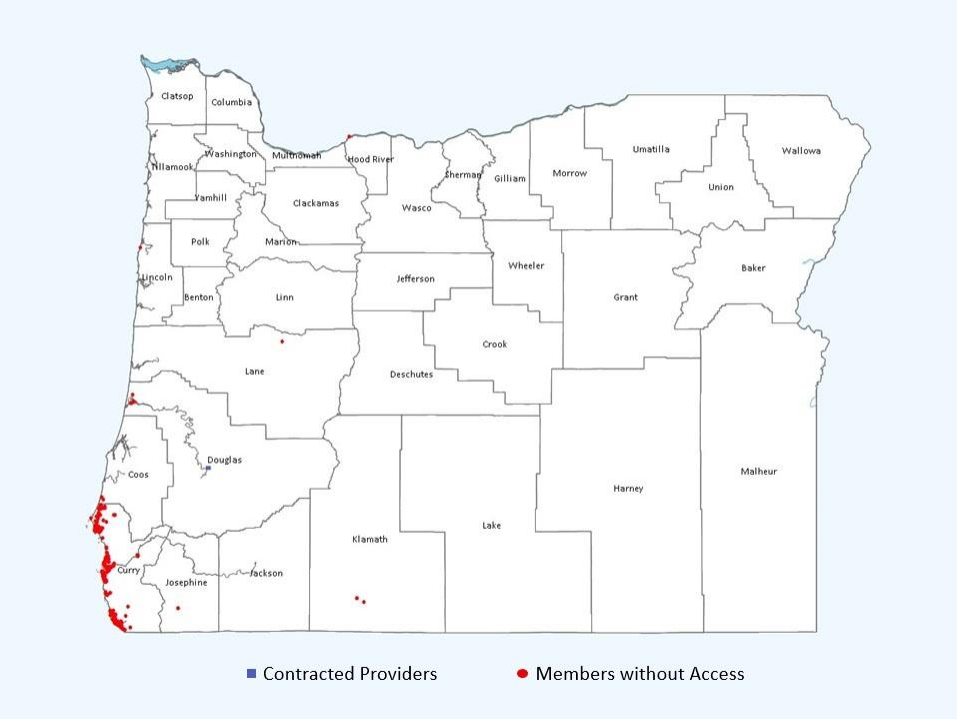
DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of AH's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Coos County and Curry County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards, except for some member access to individual pediatric practitioners in Curry County.

All of the ZIP Codes within AH's service area were classified as rural. As shown below in Figure B-1, the graphic representation illustrates pediatric members residing in rural areas without access to SUD pediatric practitioners within 60 miles/minutes. HSAG's analysis identified an aggregated count of six SUD pediatric practitioners at one location. Of the 7,958 AH pediatric members, 826 (10.4 percent) were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of AH's service area.

Figure B-1—AH—Rural Members Without Access to SUD Pediatric Practitioners



Provider Network Quality and Count Results

The DSN Provider Capacity Report is an inventory of each individual provider (i.e., physician, mid-level practitioner, or other practitioner), facility, or business, whether employed by or under subcontract with a CCO, or paid FFS, that agrees to provide the described services, or items, to Medicaid and fully dual-eligible CCO members. Containing an inventory of the provider categories and service categories outlined in Exhibit G of the CCO contract, HSAG evaluated the data to assess general capacity of each CCO's existing and proposed DSN.

AH submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was excellent with no notable data quality issues.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 606 individual practitioner and 55 facility/business/service provider data records of contracted providers. Table B-2 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of AH's DSN Provider Capacity Report submission:

- Of the 606 total counted individual practitioners, 485 data records were identified as contracted and in-network providers. The geographic distribution of data records was 378 in Coos County, 94 in Curry County, and 13 in a county that does not border the CCO's service area.
- Of the 55 total counted facility/business/service providers, 49 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 39 in Coos County and 10 in Curry County.
- No Certified or Qualified Health Care Interpreters or Palliative Care individual practitioner data records were populated.
- No Urgent Care Center facility/business/service provider data records were populated.
- Five Ambulance and Emergency Medical Transportation data records were populated; however, none were identified as contracted and in-network providers.
- Of the 45 total counted SUD Provider data records, 27 were in-network individual practitioners who all identified as adult providers. The remaining 18 were out-of-network providers, consisting of 12 adult and six pediatric providers, who rendered care in Douglas and Josephine counties.
- Of the 45 total counted SUD Provider data records, none of the providers were identified as speaking a non-English language.
- Of the 195 total counted MH Provider data records, 128 were identified as pediatric providers. Of those, 90 were identified as in-network providers. The remaining 38 were identified as out-of-network providers, all located in the neighboring Douglas County.

Table B-2—Individual Practitioner and Facility/Business/Service Provider Counts for AH

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	89	14.7%	89	18.4%	0	0.0%
Specialty Provider	169	27.9%	141	29.1%	28	23.1%
Oral Health Provider	75	12.4%	75	15.5%	0	0.0%
MH Provider	195	32.2%	122	25.2%	73	60.3%
SUD Provider	45	7.4%	27	5.6%	18	14.9%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%	0	0.0%
Traditional Health Workers	18	3.0%	16	3.3%	2	1.7%
Health Education, Health Promotion, Health Literacy	15	2.5%	15	3.1%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**606**	**100.0%**	**485**	**100.0%**	**121**	**100.0%**
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	1	1.8%	1	2.0%	0	0.0%
Ambulance and Emergency Medical Transportation	5	9.1%	0	0.0%	0	0.0%
Federally Qualified Health Centers	2	3.6%	2	4.1%	0	0.0%
Home Health	2	3.6%	2	4.1%	0	0.0%
Hospice	2	3.6%	2	4.1%	0	0.0%
Hospital	4	7.3%	4	8.2%	0	0.0%
Imaging	5	9.1%	5	10.2%	0	0.0%
Indian Health Service and Tribal Health Services	1	1.8%	1	2.0%	0	0.0%
MH Crisis Services	1	1.8%	1	2.0%	0	0.0%
Community Prevention Services	2	3.6%	2	4.1%	0	0.0%
Non-Emergent Medical Transportation	1	1.8%	1	2.0%	0	0.0%
Pharmacies	17	30.9%	16	32.7%	1	100.0%
Durable Medical Providers	3	5.5%	3	6.1%	0	0.0%
Post-hospital Skilled Nursing Facility	6	10.9%	6	12.2%	0	0.0%
Rural Health Centers	2	3.6%	2	4.1%	0	0.0%
School-based Health Centers	1	1.8%	1	2.0%	0	0.0%
Urgent Care Center	0	0.0%	0	0.0%	0	0.0%
Overall	**55**	**100.0%**	**49**	**100.0%**	**1**	**100.0%**

[1] Limited to providers in Oregon.

[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

AllCare CCO, Inc.

DSN Provider Narrative Evaluation Results

AllCare CCO, Inc. (AllCare) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Curry, Jackson, and Josephine counties, as well as parts of Douglas County.

The CCO submitted a DSN Provider Narrative Report with detailed responses, accompanied with policies, desktop procedures, data dashboards, analytics, and other supporting documentation to further demonstrate DSN-related monitoring and oversight mechanisms.

AllCare required its delegated/subcontracted providers to submit all provider network changes by the first Friday of every month in a format that mirrors the OHA DSN Provider Capacity Report Template. AllCare incorporated these data into its monthly reconciliation of network adequacy analysis. The CCO reported that, due to the continued complaints related to oral health access, AllCare placed one of its DCOs on a CAP that was effective April 2019. The Access to Care Remediation Plan was submitted as supporting documentation, and demonstrated the action items, targeted dates of completion, and progress updates. Review of the Access to Care Remediation Plan indicated that regular meetings/check-ins occurred to ensure that oral health providers and specialists were hired or contracted to cover other offices to ensure that the access to care issues were resolved. It appeared that the CAP was closed as of February 2020.

AllCare included a comprehensive description of the various types of THWs available to members directly from the CCO, contracted provider groups, and community stakeholders, as well as a detailed account of the role/responsibilities. The CCO considered its capacity and availability of THWs sufficient. The CCO's analysis indicated that one THW has the capacity of 50 members being assigned per month. AllCare submitted its THW Community Integration Plan, which included, but was not limited to, expanding its THW policy framework, implementing a THW Community Collaboration to function as an oversight that monitors utilization of THWs in the community, and implementing program goals aligned with increasing external and internal contracted and credentialed THWs.

AllCare used a health care analytic tool to analyze member-level acuity, disease prevalence, and utilization. The CCO monitored quarterly and annual reporting as part of its Population Health Program. Any population health employee could generate a report and stratify the data to compare across specific diseases or the many information data fields incorporated in the report. AllCare submitted supporting documentation to demonstrate the prevalence of disease across the top 20 members with the highest total expenses and medical loss ratios, screen shots to illustrate stratification of this report, and Health Care Cost Task Force meeting minutes to give an instance of reporting being review and discussed.

Table B-3 provides the complete AllCare DSN Provider Narrative Report evaluation results.

Table B-3—AllCare—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0.5	**Findings**: AllCare's narrative response described using internal and delegated provider data to reconcile and cross-reference its data, identifying its membership within each ZIP Code to conduct its network capacity analysis. The CCO submitted its network capacity reporting to demonstrate its analysis by physician specialty type and county; however, the analysis did not include MH/BH, SUD, or oral health providers in its reporting. Additionally, the CCO did not describe the geocoding application or software used by the CCO to conduct analysis. AllCare's response also lacked geocoding analysis to demonstrate the geographic distribution and member access to care. **Recommendation for the Next Submission:** AllCare should describe how geocoding application or software is used by the CCO to conduct analysis. AllCare should also describe its process and/or procedure for conducting an analysis of the geographic distribution of all providers (i.e., PCPs, specialists, MH/BH, SUD, and oral health) compared to the geographic distribution of members.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0	**Findings**: AllCare described using internal and delegated provider data to reconciliate and cross-reference its data, identifying its membership within each ZIP Code to conduct its network capacity analysis; however, the CCO did not clearly describe its methodology for calculating the time (minutes), distance (miles), and percentage of access standard reporting for all of the provider and facility types listed in the element. The CCO submitted analysis to demonstrate calculating the number of members within each county that have access to various specialty providers, the maximum distance in miles for a member to have access, and an overall percentage of members

Category Elements		Score	Findings/Recommendations
			with access to open providers; however, the submission did not specifically include MH/BH, SUD, or oral health providers in its time, distance, and percentage standard reporting. **Recommendation for the Next Submission:** AllCare should use the precise location of the closest participating DSN provider (i.e., adult and pediatric PCPs, adult and pediatric specialists, adult and pediatric MH providers, adult and pediatric SUD providers, adult and pediatric oral health providers, PCPCHs, acute hospitals, OB/GYNs, and pharmacies) and the member's address to calculate the CCO's time (minutes), distance (miles), and overall member access (percent) standards. The CCO should analyze, describe, and submit its time and distance analysis to demonstrate member access to care within the time, distance, and percentage standards.
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's narrative response provided a detailed account of procedures in place for monitoring and analyzing wait times for MH and SUD providers. The CCO also briefly described that AllCare's appeals and grievance department and internal committees reviewed, monitored, tracked, and trended any access-related complaints, denials, and appeals, but did not describe policies, procedures, and activities conducted to monitor wait times for appointments with providers (PCPs), including specialists (physical and oral health providers). Additionally, the response did not address how the CCO analyzed its monitoring activities to ensure whether or not members can receive timely access to appointments.

Category Elements		Score	Findings/Recommendations
			Recommendation for the Next Submission: AllCare should describe how the CCO 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	**Findings**: AllCare's narrative response focused on member access to BH and SUD services. The CCO referenced a new BH Access policy; however, the policy only stated the expected time and distance standard. There was no mention of any activities conducted to monitor and ensure time, distance, and percentage standards for member access to MH specialists. AllCare's narrative response did not incorporate what activities are conducted and how the CCO analyzes and ensures compliance. The narrative should address whether the CCO considers member access to specialty care (physical and oral health) is sufficient for members to receive timely access to care. **Recommendation for the Next Submission:** AllCare should describe how it analyzes and ensures compliance and address whether the CCO considers member access to specialty care (physical and oral health) is sufficient for members to receive timely access to care.
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	**Findings**: AllCare submitted a supporting document that demonstrates the ratio of 1,000 providers to members for PCPs and some specialty providers; however, the CCO did not specifically describe the ratio of members to providers for MH practitioners, SUD treatment providers, dental care providers, and the availability of acute care beds. Additionally, the CCO did not describe its process and/or methodology for calculating and analyzing the ratio of members (pediatric, adult, and geriatric) to providers for PCPs, specialists, MH practitioners, SUD treatment providers, dental care providers, and the availability of acute care beds.

Category Elements		Score	Findings/Recommendations
			Recommendation for the Next Submission: AllCare should describe its process and/or methodology for calculating and analyzing the ratio of members (pediatric, adult, and geriatric) to MH practitioners, SUD treatment providers, dental care providers, and the availability of acute care beds.
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	**8.0**	**Out of Possible 12.0**

Category Elements		Score	Findings/Recommendations
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 surveys; and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CCO needs to describe how it uses the input from its community advisory council.	0.5	**Findings**: AllCare's narrative response explained that members seen by providers that participate in its APMs are surveyed annually on patient satisfaction and access to care. Additionally, AllCare described that, as part of its 2020–2022 Health Equity Plan, listening sessions were conducted with Native American, Severe and Persistent Mental Illness (SPMI), and Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersexed, Agender, Asexual, and Ally community (LGBTQIA+) members to receive feedback about their experiences and access to care; however, the CCO did not specifically address whether or not adult (MHSIP), family (YSS-F), and child (YSS) MH surveys, as well as CAHPS surveys were used to gather member feedback, and describe how the feedback was incorporated into network adequacy decisions.

Category Elements		Score	Findings/Recommendations
			Recommendation for the Next Submission: AllCare should describe how it incorporates member feedback from adult (MHSIP), family (YSS-F), and child (YSS) MH surveys, as well as CAHPS surveys that are used to gather member feedback, and describe how the feedback is incorporated 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**
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	0.5	**Findings**: AllCare's narrative response and submitted policies demonstrated the role of its interdisciplinary care teams across the continuum of care. However, the CCO did not describe its

Category Elements		Score	Findings/Recommendations
	analyzes whether it considers this adequate to reduce hospital readmission and emergency room usage.		process/methodology for analyzing whether the use of interdisciplinary care teams to coordinate services is considered adequate to reduce hospital readmission and emergency room usage and address whether the CCO considers these efforts adequate. **Recommendation for the Next Submission:** AllCare should describe its process/methodology for analyzing whether the use of interdisciplinary care teams to coordinate services is considered adequate to reduce hospital readmission and emergency room usage and address whether the CCO considers these efforts adequate.
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	**4.5**	**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**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of AllCare's network of individual practitioners compared to its membership was sufficient to cover most of the CCO's service area (i.e., Curry County, Josephine County, Jackson County, and part of Douglas County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards, except for some member access to individual pediatric practitioners and PCPCHs in concentrated areas scattered across all four counties. An assessment of the geographic distribution of facilities compared to AllCare's membership was unable to be conducted because the CCO's submitted DSN Provider Capacity Report did not include any data records identified as the Provider Category Description of Facility "04" or Business or Healthcare Services "05."

Most of the ZIP Codes within AllCare's service area are classified as rural with the exception of the areas surrounding Medford and Phoenix/Talent. As shown below in Figure B-2 and Figure B-3, the graphic representations illustrate pediatric members without access to SUD pediatric practitioners within AllCare's service area. HSAG's analysis identified no SUD pediatric practitioners. All 12,814 (100 percent) pediatric members residing in urban-classified areas were without access within 30 miles/minutes in the CCO's service area. Likewise, as a result of no SUD pediatric practitioners, 4,635 (100 percent) pediatric members residing in rural classified areas were without access within 60 miles/minutes in the CCO's service area.

Figure B-2—AllCare—Urban Members Without Access to SUD Pediatric Practitioners

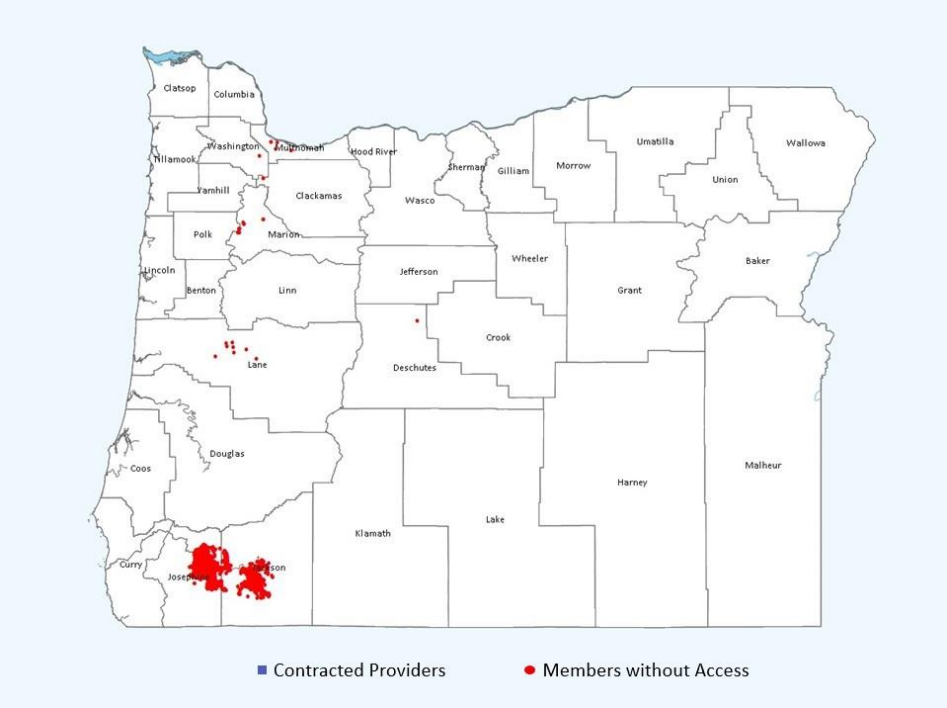
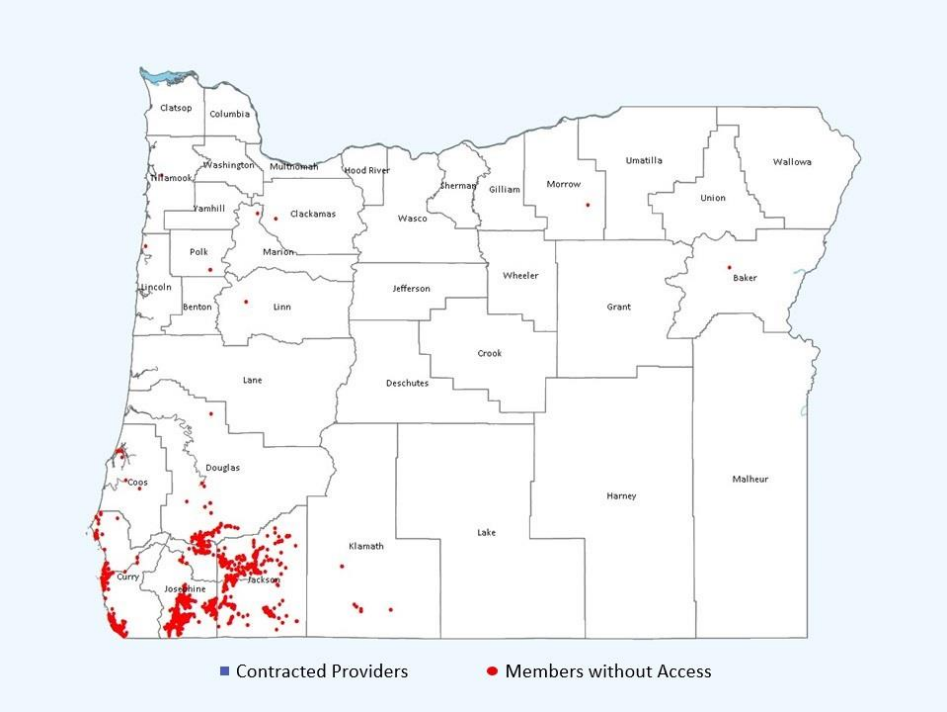


Figure B-3—AllCare—Rural Members Without Access to SUD Pediatric Practitioners



As shown below in Figure B-4 and Figure B-5, the graphic representations illustrate members without access to PCPCH practitioners and facilities within AllCare's service area. HSAG's analysis identified no PCPCH practitioners and facilities. All 35,940 (100 percent) members residing in urban classified areas are without access within 30 miles/minutes in the CCO's service area. Likewise, as a result of no PCPCH practitioners and facilities, 15,166 (100 percent) members residing in rural classified areas are without access within 60 miles/minutes in the CCO's service area.

Figure B-4—AllCare—Urban Members Without Access to PCPCH Practitioners and Facilities

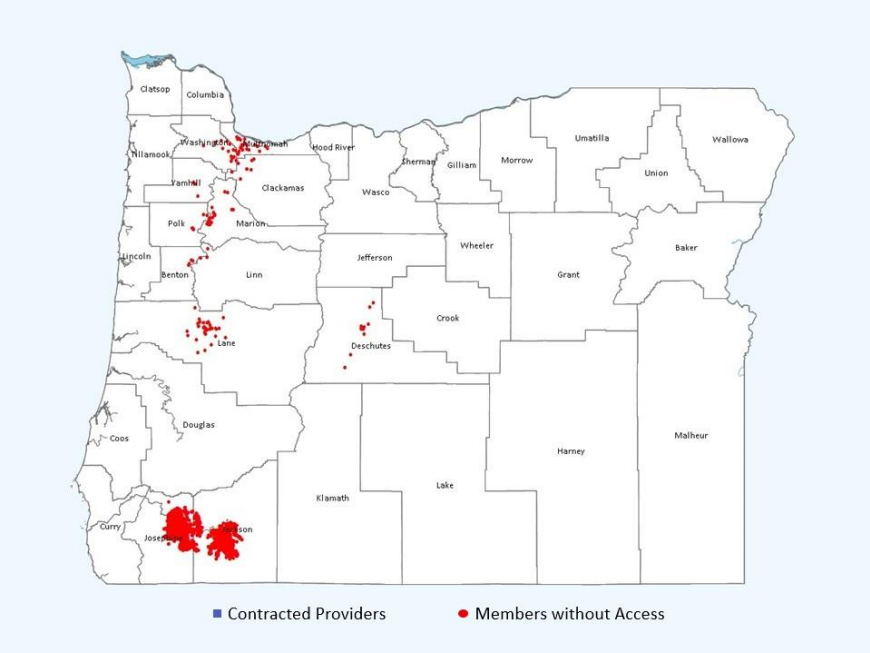
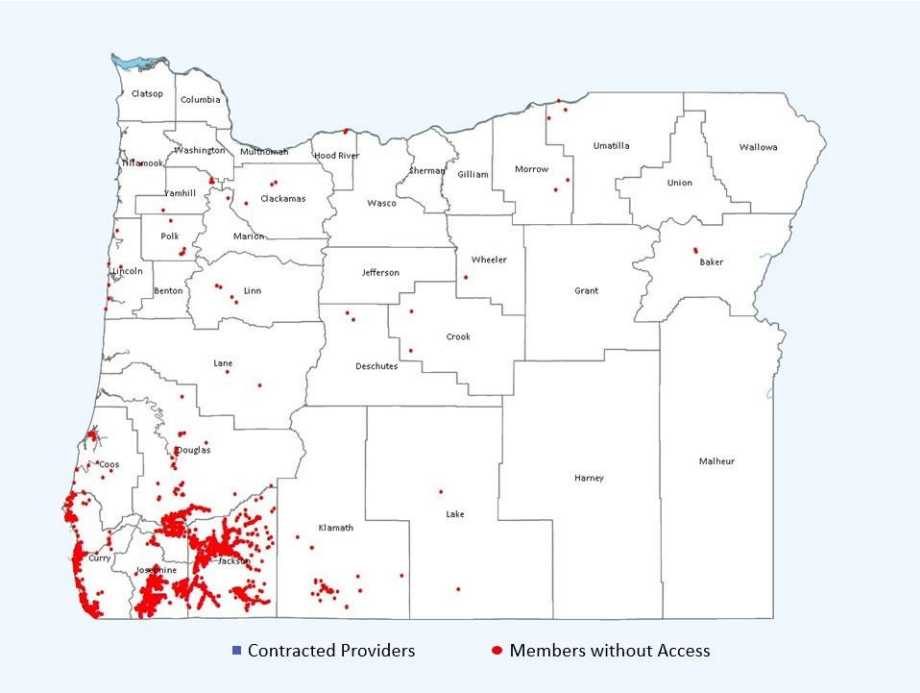


Figure B-5—AllCare—Rural Members Without Access to PCPCH Practitioners and Facilities



Provider Network Quality and Count Results

AllCare submitted a DSN Provider Capacity Report that contained all of the required data fields; however, the report did not include any data records identified as the Provider Category Description of Facility "04" or Business or Healthcare Services "05." The quality of the CCO's submitted individual practitioner data records were fair with a few data quality issues. The following areas of concern were observed in AllCare's report:

- All (100 percent) of the Provider Service Category data fields included values; however, only 81.5 percent were valid values. "DSPA/DSPP" and "MMPA," which are both invalid values, were populated in multiple data records.
- Multiple Lang1 and PCPCH_Tier data fields with values were populated with the null value of "NA."
- All (100 percent) of the Credentialing Date data fields had values populated; however, 93.6 percent of the values were valid.
- All (100 percent) of the Status of Medicaid Contract data fields had values populated; however, none were valid formats and values.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 2,032 individual practitioner and no facility/business/service provider data records of contracted providers. Table B-4 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of AllCare's DSN Provider Capacity Report submission:

- Of the 2,032 total counted individual practitioners, all of the data records were identified as contracted and in-network providers. The geographic distribution of the data records was 95 in Curry County, 570 in Josephine County, 1,306 in Jackson County, 48 in two counties that border the CCO's service area, and the remaining 13 in four non-bordering counties.
- No Traditional Health Workers or Palliative Care individual practitioner data records were populated.
- No facility/business/service provider data records were populated.
- Of the seven total counted Oral Health Provider data records, five were identified as adult providers, six were identified as pediatric providers, and one was identified as rendering care to both adult and pediatric members.
- Of the seven total counted Oral Health Provider data records, none of the providers were identified as speaking a non-English language.
- Of the 30 SUD Provider data records, all were identified as adult providers and only three were identified as speaking a non-English language.

Table B-4—Individual Practitioner and Facility/Business/Service Provider Counts for AllCare

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	400	19.7%	400	19.7%	0	0.0%
Specialty Provider	1,146	56.4%	1,146	56.4%	0	0.0%
Oral Health Provider	7	0.3%	7	0.3%	0	0.0%
MH Provider	439	21.6%	439	21.6%	0	0.0%
SUD Provider	30	1.5%	30	1.5%	0	0.0%
Certified or Qualified Health Care Interpreters	5	0.2%	5	0.2%	0	0.0%
Traditional Health Workers	0	0.0%	0	0.0%	0	0.0%
Health Education, Health Promotion, Health Literacy	5	0.2%	5	0.2%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**2,032**	**100.0%**	**2,032**	**100.0%**	**0**	0.0%
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	0	—	0	—	0	—
Ambulance and Emergency Medical Transportation	0	—	0	—	0	—
Federally Qualified Health Centers	0	—	0	—	0	—
Home Health	0	—	0	—	0	—
Hospice	0	—	0	—	0	—
Hospital	0	—	0	—	0	—
Imaging	0	—	0	—	0	—
Indian Health Service and Tribal Health Services	0	—	0	—	0	—
MH Crisis Services	0	—	0	—	0	—
Community Prevention Services	0	—	0	—	0	—
Non-Emergent Medical Transportation	0	—	0	—	0	—
Pharmacies	0	—	0	—	0	—
Durable Medical Providers	0	—	0	—	0	—
Post-hospital Skilled Nursing Facility	0	—	0	—	0	—
Rural Health Centers	0	—	0	—	0	—
School-based Health Centers	0	—	0	—	0	—
Urgent Care Center	0	—	0	—	0	—
Overall	**0**	**—**	**0**	**—**	**0**	**—**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Cascade Health Alliance, LLC

DSN Provider Narrative Evaluation Results

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

CHA submitted a DSN Provider Narrative Report with limited responses that lacked detail. The CCO's Annual 2020 CCO DSN Provider Narrative Report Template submission had two additional tabs titled "DSN Map" and "Member Demographics." Each tab had a PDF document embedded; however, neither document could be opened or accessed. The CCO did not reference either of the embedded documents in any of its narrative response. CHA's narrative response was not accompanied by any supplemental documentation to further demonstrate how the CCO ensures, monitors, and evaluates the adequacy of its provider network.

The CCO reported establishing a Provider Network Management Committee to oversee and review geo-mapping time and distance data; wait times; and appropriate access to urgent, emergency, crisis, and triage services 24 hours a day/7 days a week. The CCO stated that, in instances in which the standards are not met, the Provider Network Management Committee will implement an initial CAP to address the identified deficiencies; this process ensures that corrective strategies, action items, and deliverables are documented with corresponding dates. Further, the CCO reported that the Provider Network Management Committee establishes, implements, and monitors the CAP to confirm the achievement of standard compliance.

CHA's narrative response described the adjustments made to its DSN by implementing and fostering new community partnerships that increased the number of THWs by three; one THW separately supporting primary care, BH, and health-related service providers. The CCO reported 30 THWs within its geographic service area, of which only 19 were certified. CHA outlined its roadmap and goals to increase the total amount of THWs accessible within its DSN. CHA did not have a mechanism to identify measurable outcomes and effectiveness of THW services but was in the process of developing an action plan to capture and validate both.

Table B-5 provides the complete CHA DSN Provider Narrative Report evaluation results.

Table B-5—CHA—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0	**Findings**: CHA's narrative response addressed the percentage of members that have access to adult and pediatric services rendered by PCPs; specialists; and MH/BH, SUD, and oral health providers. The CCO did not describe its process and/or procedure for conducting an analysis of the geographic distribution of all providers, whether the comparison of the geographic distribution of providers with the geographic distribution of its membership was considered adequate, and the ongoing monitoring efforts conducted to ensure member access to covered services within its DSN system. Additionally, the CCO did not describe which geocoding application or software is used or submit its geocoding analysis to demonstrate geographic distribution and member access to care. CHA's Annual 2020 CCO DSN Provider Narrative Report Template had an additional tab titled "DSN Map." The embedded document could not be opened or accessed. **Recommendation for the Next Submission:** CHA should describe the geographic distribution of all providers (i.e., PCPs, specialists, MH/BH, SUD, and oral health) compared with the geographic distribution of members. The CCO should also include geocoding analysis to demonstrate geographic distribution and member access to care.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0	**Findings**: CHA's narrative response provided a limited description of how the CCO used the members' full address and provider information to create geospatial data for mapping time and distance; however, the CCO did address the frequency in which it evaluates the time and distance standards. The CCO reported its calculations for miles and percent of overall member access standards in response to element #1; however, these calculations did not match the minutes, miles, and percentages reported in the Time and Distance Standards Reporting

Category Elements		Score	Findings/Recommendations
			section of the Annual 2020 CCO DSN Provider Narrative Report Template. Additionally, CHA did not address whether its member access to health care is in compliance based on its time and distance calculations. **Recommendation for the Next Submission:** CHA should discuss how the network ensures that the time and distance standards for member access to health care are met. The CCO should also describe the methodology used to demonstrate compliance with the three standards—time, distance, and percentage. Additionally, the CCO should submit analysis to demonstrate member access within all of the standards.
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.	0.5	**Findings**: CHA's narrative response stated the CCO monitored access to care and availability by performing validation through service area calls, member grievances, and customer service calls, assessing hours and availability; however, the CCO's limited description did not include the process and/or procedures for the listed monitoring mechanisms or the frequency of the activities. Additionally, the CCO did not address how the monitoring activities are analyzed and how it determines if the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days week for all members is adequate, and whether the CCO considers its access adequate. **Recommendation for the Next Submission:** CHA should describe its process and/or procedures for the listed monitoring mechanisms, or the frequency of the activities conducted to ensure the provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members. Additionally, the CCO should describe how it analyzes and determines whether the access is considered adequate.
4.	CCO analyzes wait times for appointments with providers, including specialists.	0.5	**Findings**: CHA's narrative response stated the CCO wait times are assessed through member complaints, CAHPS survey results, and a

Category Elements		Score	Findings/Recommendations
			secret shopper phone call to inquire about the next available appointment for PCPs and specialists; however, the CCO's limited description did not include the procedures of the listed monitoring mechanisms or the frequency of the activities. Additionally, the CCO did not address how it analyzes its activities to ensure compliance and address whether the DSN is adequate for members to receive timely access to appointments with providers, including specialists. **Recommendation for the Next Submission:** CHA should describe the process and/or procedures for the listed monitoring mechanisms, the frequency of the activities, how the CCO analyzes its activities to ensure compliance, and address whether the DSN is adequate for members to receive timely access to 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	**Findings**: CHA's narrative response did not describe its process and/or procedure for conducting analysis to monitor and ensure time, distance, and percentage standards for member access to specialists (physical, mental, and oral health providers). Additionally, CHA did not address how it ensures compliance and whether the CCO considers member access to specialty care is sufficient for members to receive timely access to care. **Recommendation for the Next Submission:** CHA should describe its process and/or procedure for conducting analysis to monitor and ensure time, distance, and percentage standards for member access to specialists (physical, mental, and oral health providers) and how it ensures compliance and whether the CCO considers member access to specialty care is sufficient for members to receive timely access to care.
6.	CCO describes the ratio of members to providers for primary care providers, specialists, mental health practitioners, substance use disorder treatment	0.5	**Findings**: CHA's narrative response described the count of members and providers and the calculation of ratios specifically for members to providers for PCPs, specialists, MH practitioners, SUD treatment

Category Elements		Score	Findings/Recommendations
	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.		providers, oral health providers, and the availability of acute care beds; however, the CCO did not describe how it analyzes its ratios to verify whether member access to health care is in compliance. **Recommendation for the Next Submission:** CHA should describe how it analyzes its ratios to verify whether member access to health care is in compliance.
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**: CHA's narrative response described that the availability of THWs by type considers member access to THWs adequate; however, the CCO did not address how it analyzes access and determines whether the availability to THWs is adequate. Additionally, CHA did not report the calculated ratio of THWs to members. **Recommendation for the Next Submission:** CHA should describe how it analyzes access, determines whether the availability to THWs is adequate, and report the calculated ratio of THWs to 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**: CHA's narrative response identified that NEMT services are contracted through Sky Lakes Medical Center (SLMC), a local FQHC, and the THWs are employed by SLMC; however, the CCO did not specifically describe its process and/or procedure for monitoring and analyzing NEMT services. Additionally, CHA did not address how it conducts oversight/monitoring of the subcontracted NEMT services, ensuring adequate access. **Recommendation for the Next Submission:** CHA should describe its process and/or procedure for monitoring and analyzing NEMT services and how the CCO conducts oversight/monitoring of the subcontracted NEMT services, ensuring adequate access.
9.	CCO addresses transportation and access for members with disabilities or special needs. The CCO should	0.5	**Findings**: CHA's narrative response described that most members identified as having special health care needs are aligned with a THW,

Category Elements		Score	Findings/Recommendations
	analyze and describe whether the CCO considers this adequate.		which provides 1:1 NEMT services; however, the CCO did not specifically describe its process and/or procedure for monitoring, analyzing, and determining if NEMT access is adequate for its SHCN membership. Additionally, CHA did not address how it conducts ongoing oversight/monitoring of the subcontracted NEMT services, ensuring adequate access. **Recommendation for the Next Submission:** CHA should describe its process and/or procedure for monitoring and analyzing NEMT services for SHCN members and how the CCO conducts oversight/monitoring of the subcontracted NEMT services, ensuring adequate access.
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**: CHA's narrative response described several mechanisms in place to assist members through various scenarios of a member's continuum of care and the CCO's collaborative efforts with contract MH providers to ensure continuity of care; however, the CCO did not specifically describe how it provides, monitors, and analyzes a continuum of care for MH disorders for crisis, outpatient, and intensive outpatient care for adults and children, including but not limited to ACT, DBT, ICTS, and residential/inpatient. **Recommendation for the Next Submission:** CHA should describe how it provides, monitors, and analyzes a continuum of care for MH disorders for crisis, outpatient, and intensive outpatient care for both adults and children, including but not limited to ACT, DBT, ICTS, and 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.	0.5	**Findings**: CHA's narrative response described several mechanisms in place to assist members through various scenarios of a member's continuum of care and its partnerships with SUD providers across the state; however, the CCO did not specifically describe how it monitors and analyzes a continuum of care for treatment of SUD for both adults and pediatric memberships.

Category Elements		Score	Findings/Recommendations
			Recommendation for the Next Submission: CHA should describe how it monitors and analyzes a continuum of care for treatment of SUD for both adults and pediatric memberships.
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	**5.0**	**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**: CHA's narrative response described several mechanisms in place to identify member characteristics such as cultural, language, disability, and special health care needs and ensure assignment to an appropriate provider; however, the CCO did not specifically describe its process and/or procedure for conducting analysis of member characteristics. Additionally, the CCO did not submit cultural, language, disability, and special health care needs analysis to demonstrate the characteristics of the CCO's membership. **Recommendation for the Next Submission:** CHA should describe its process and/or procedure for conducting analysis of its membership's cultural, language, disability, and special health care needs and submit analysis to demonstrate these characteristics.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	0	**Findings**: CHA's narrative response described how its CM department generates a report on its top 20 conditions, and how the CCO also reported working with a health care analytics data company to offer help to contracted providers and clinics with assessing the risk gaps of their members; however, the CCO did not submit analysis

Category Elements		Score	Findings/Recommendations
			demonstrating the prevalence of diseases that require access to specialists. **Recommendation for the Next Submission:** CHA should submit analysis to demonstrate the prevalence of diseases that require access to specialists among the CCO's membership.
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 surveys; and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CCO needs to describe how it uses the input from its community advisory council.	0.5	**Findings**: CHA's narrative response described how the member survey and grievance data were used to create a dashboard that was reviewed by internal committees, contracted providers, and its CAC to assist with network adequacy decisions and used to make network adequacy decisions; however, the CCO did not specifically address its process and/or procedure for incorporating input from its CAC into network adequacy decisions. Additionally, CHA did not include an example, scenario, or supporting documentation to demonstrate how input from its CAC was incorporated into network adequacy decisions." **Recommendation for the Next Submission:** CHA should describe its process and/or procedure for incorporating input from its CAC into network adequacy decisions and incorporate examples, applicable scenarios, and/or supporting documentation demonstrating how the CCO incorporates input from its CAC 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	1	Met

Category Elements		Score	Findings/Recommendations
	training in self-care and other interventions, 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	**3.5**	**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	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

Category Elements		Score	Findings/Recommendations
	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.	0	**Findings**: CHA's narrative response described its process to address provider network capacity measurement concerns; however, the CCO did not specifically describe any metrics in which CHA is performing below the baseline. Additionally, CHA's response did not include examples, applicable scenarios, and/or supporting documentation to demonstrate CCO efforts to build its network capacity to improve performance on metrics. **Recommendation for the Next Submission:** CHA should describe any metrics in which the CCO is performing below the baseline. Additionally, the CCO did not include examples, applicable scenarios, and/or supporting documentation to demonstrate CCO efforts to build its network capacity to improve performance on metrics.
26.	CCO analyzes patterns of underutilization and overutilization and the actions the CCO has taken to address underutilization and overutilization.	0.5	**Findings**: CHA's narrative response did not incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate action taken to address underutilization." **Recommendation for the Next Submission:** CHA should incorporate an example, applicable scenario, and/or supporting documentation to demonstrate actions taken by the CCO to address overutilization.
	Total Score	**0.5**	**Out of Possible 2.0**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of CHA's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover the CCO's service area (i.e., Klamath County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards. All of the ZIP Codes within CHA's service area are classified as rural. No deficiencies were assessed, validating that 90 percent of CHA's adult and pediatric members had access to all required provider service categories.

Provider Network Quality and Count Results

CHA submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was good with a few data quality issues. The following areas of concern were observed in CHA's report:

- Of all the records submitted, only 86.8 percent of the providers had the TIN data field populated.
- Of the individual practitioner data records submitted, only 39.3 percent of the providers had the Credentialing Date data field values populated.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 857 individual practitioner and 53 facility/business/service provider data records of contracted providers. Table B-6 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of CHA's DSN Provider Capacity Report submission:

- Of the 857 total counted individual practitioners, 619 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 585 in Klamath County, 25 in three counties that bordered the CCO's service area, and the remaining nine in eight non-bordering counties.
- Of the 53 total counted facility/business/service providers, eight data records were identified as contracted and in-network providers. The geographic distribution of the data records was four in Klamath County, two in one county that bordered the CCO's service area, and the remaining two in two non-bordering counties.
- Of the 28 total counted Traditional Health Workers data records, all were in-network providers; however, none of the providers were identified as speaking a non-English language.
- No Certified or Qualified Health Care Interpreters or Palliative Care individual practitioner data records were populated.

- No Indian Health Service and Tribal Health Services or Urgent Care Center facility/business/service provider data records were populated.
- Two Health Education, Health Promotion, Health Literacy data records were populated; however, neither was identified as contracted and in-network providers.
- One Hospital, Acute Psychiatric Care data record was populated; however, it was not identified as a contracted and in-network provider.
- Eight Ambulance and Emergency Medical Transportation data records were populated; however, none were identified as contracted and in-network providers.
- Two Hospice data records were populated; however, neither was identified as a contracted and in-network provider.
- Two Imaging data records were populated; however, neither was identified as a contracted and in-network provider.
- One MH Crisis Services data record was populated; however, it was not identified as a contracted and in-network provider.
- One Community Prevention Services data record was populated; however, it was not identified as a contracted and in-network provider.
- One Non-Emergent Medical Transportation data record was populated; however, it was not identified as a contracted and in-network provider.
- Ten Pharmacies data records were populated; however, none were identified as contracted and in-network providers.
- One Post-hospital Skilled Nursing Facility data record was populated; however, it was not identified as a contracted and in-network provider.
- One School-based Health Centers data record was populated; however, it was not identified as a contracted and in-network provider.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-6—Individual Practitioner and Facility/Business/Service Provider Counts for CHA

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	188	21.9%	136	22.0%	0	0.0%
Specialty Provider	275	32.1%	130	21.0%	0	0.0%
Oral Health Provider	32	3.7%	25	4.0%	0	0.0%
MH Provider	286	33.4%	260	42.0%	0	0.0%
SUD Provider	46	5.4%	40	6.5%	0	0.0%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%	0	0.0%

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	**Number**	**Percent[2]**	**Number**	**Percent[2]**	**Number**	**Percent[2]**
Traditional Health Workers	28	3.3%	28	4.5%	0	0.0%
Health Education, Health Promotion, Health Literacy	2	0.2%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**857**	**100.0%**	**619**	**100.0%**	**0**	0.0%
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	1	1.9%	0	0.0%	0	0.0%
Ambulance and Emergency Medical Transportation	8	15.1%	0	0.0%	0	0.0%
Federally Qualified Health Centers	3	5.7%	1	12.5%	0	0.0%
Home Health	1	1.9%	1	12.5%	0	0.0%
Hospice	2	3.8%	0	0.0%	0	0.0%
Hospital	14	26.4%	4	50.0%	0	0.0%
Imaging	2	3.8%	0	0.0%	0	0.0%
Indian Health Service and Tribal Health Services	0	0.0%	0	0.0%	0	0.0%
MH Crisis Services	1	1.9%	0	0.0%	0	0.0%
Community Prevention Services	1	1.9%	0	0.0%	0	0.0%
Non-Emergent Medical Transportation	1	1.9%	0	0.0%	0	0.0%
Pharmacies	10	18.9%	0	0.0%	0	0.0%
Durable Medical Providers	6	11.3%	1	12.5%	0	0.0%
Post-hospital Skilled Nursing Facility	1	1.9%	0	0.0%	0	0.0%
Rural Health Centers	1	1.9%	1	12.5%	0	0.0%
School-based Health Centers	1	1.9%	0	0.0%	0	0.0%
Urgent Care Center	0	0.0%	0	0.0%	0	0.0%
Overall	**53**	**100.0%**	**8**	**100.0%**	**0**	0.0%

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Columbia Pacific CCO, LLC

DSN Provider Narrative Evaluation Results

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

The CCO submitted a DSN Provider Narrative Report with comprehensive and detailed responses, accompanied with policies, processes, workflows, data dashboards, and analytics to further demonstrate DSN-related monitoring and oversight mechanisms.

CPCCO reported using the Quest Analytics tool to conduct quarterly time and distance analysis. The CCO also used the geocoding software to identify non-contracted providers that a contract could be initiated with to expand the network deliver system. Quest Analytics geocoding, maps, and analysis were refreshed, reported, and reviewed at the monthly Network Adequacy Steering Committee meetings. If any network gaps were identified, the committee constructed a plan to mitigate any barriers to member access to care.

CPCCO delegated oral health services to four DCOs. The delegated DCOs were required to have policies that reflect network adequacy standard expectations, how these standards are monitored, and the process to evaluate member-to-provider time and distance, ensuring network access and capacity. As part of CPCCO's monitoring and oversight, the CCO generated weekly dental provider capacity reports by county, which were shared with the DCOs for their own plan-specific monitoring.

CPCCO described multiple reports and activities conducted regularly for monitoring appropriate over- and underutilization of physical, behavioral, and oral health services at both the member and provider levels. For instance, the CCO used the panel coordinators to monitor and analyze the utilization of members to identify performance measure gaps in care of services that members should have received based on their age and/or specific diagnoses. CPCCO described this activity as a collaborative effort in which the panel coordinator engages both the member and physician's office. The CCO submitted its data scrubbing instructions, outreach workflow, and sample utilization dashboard to further demonstrate its processes, procedures, and monitoring.

Table B-7 provides the complete CPCCO DSN Provider Narrative Report evaluation results.

Table B-7—CPCCO—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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

Category Elements		Score	Findings/Recommendations
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	**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

Category Elements		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	**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 surveys; and Consumer Assessment of Healthcare Providers and Systems (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

Category Elements		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**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of CPCCO's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover the CCO's service area (i.e., Clatsop County, Columbia County, and Tillamook County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards. All of the ZIP Codes within CPCCO's service area are classified as rural. No deficiencies were assessed, validating that 90 percent of CPCCO's adult and pediatric members had access to all required provider service categories.

Provider Network Quality and Count Results

CPCCO submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was excellent with no notable data quality issues.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 13,264 individual practitioner and 885 facility/business/service provider data records of contracted providers. Table B-8 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of CPCCO's DSN Provider Capacity Report submission:

- Of the 13,264 total counted individual practitioners, 709 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 281 in Clatsop County, 285 in Columbia County, 134 in Tillamook County, eight in counties bordering the CCO's service area, and the remaining one in a non-bordering county.
- Of the 885 total counted facility/business/service providers, 40 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 20 in Clatsop County, 10 in Columbia County, and 10 in Tillamook County.
- No Certified or Qualified Health Care Interpreters; Health Education, Health Promotion, Health Literacy; or Palliative Care individual practitioner data records were populated.
- No Imaging, MH Crisis Services, or Community Prevention Services facility/business/service provider data records were populated.
- Three Hospital, Acute Psychiatric Care data records were populated; however, none were identified as contracted and in-network providers.
- Three Ambulance and Emergency Medical Transportation data records were populated; however, none were identified as contracted and in-network providers.
- Twenty-three Federally Qualified Health Centers data records were populated; however, none were identified as contracted and in-network providers.

- Twelve Hospice data records were populated; however, none were identified as contracted and in-network providers.
- Two Indian Health Service and Tribal Health Services data records were populated; however, none were identified as contracted and in-network providers.
- Two School-based Health Centers data records were populated; however, neither was identified as a contracted and in-network provider.
- Of the 48 total counted Traditional Health Workers data records, eight were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining 40 contracted and out-of-network Traditional Health Workers data records, none were identified as speaking a non-English language.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-8—Individual Practitioner and Facility/Business/Service Provider Counts for CPCCO

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	6,240	47.0%	280	39.5%	5,960	47.5%
Specialty Provider	5,161	38.9%	157	22.1%	5,004	39.9%
Oral Health Provider	343	2.6%	73	10.3%	270	2.2%
MH Provider	1,106	8.3%	135	19.0%	971	7.7%
SUD Provider	366	2.8%	56	7.9%	310	2.5%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%	0	0.0%
Traditional Health Workers	48	0.4%	8	1.1%	40	0.3%
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**13,264**	**100.0%**	**709**	**100.0%**	**12,555**	**100.0%**
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	3	0.3%	0	0.0%	3	0.4%
Ambulance and Emergency Medical Transportation	3	0.3%	0	0.0%	3	0.4%
Federally Qualified Health Centers	23	2.6%	0	0.0%	23	2.7%
Home Health	20	2.3%	1	2.5%	19	2.2%
Hospice	12	1.4%	0	0.0%	12	1.4%
Hospital	41	4.6%	3	7.5%	38	4.5%
Imaging	0	0.0%	0	0.0%	0	0.0%
Indian Health Service and Tribal Health Services	2	0.2%	0	0.0%	2	0.2%

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
MH Crisis Services	0	0.0%	0	0.0%	0	0.0%
Community Prevention Services	0	0.0%	0	0.0%	0	0.0%
Non-Emergent Medical Transportation	1	0.1%	1	2.5%	0	0.0%
Pharmacies	550	62.1%	22	55.0%	528	62.5%
Durable Medical Providers	86	9.7%	3	7.5%	83	9.8%
Post-hospital Skilled Nursing Facility	89	10.1%	3	7.5%	86	10.2%
Rural Health Centers	7	0.8%	3	7.5%	4	0.5%
School-based Health Centers	2	0.2%	0	0.0%	2	0.2%
Urgent Care Center	46	5.2%	4	10.0%	42	5.0%
Overall	**885**	**100.0%**	**40**	**100.0%**	**845**	**100.0%**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Eastern Oregon CCO, LLC

DSN Provider Narrative Evaluation Results

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

The CCO submitted a DSN Provider Narrative Report with detailed responses, accompanied with policies, data dashboards, analytics, trainings, committee charters, and other supporting documentation to further demonstrate DSN-related monitoring and oversight mechanisms.

EOCCO utilized multiple forms of technology to deliver team-based care and engage providers and community stakeholders. The CCO was awarded a grant from the Health Resources and Services Administration (HRSA) for tele-behavioral care in the form of interactive videoconferencing. The grant was used to purchase and award five Community Mental Health Programs (CMHPs) with a user-friendly (patient and provider), HIPAA-compliant, browser-based tele-health platform for providing BH care services to clients. EOCCO described that the platform has the capability to collect clinical assessments from patients that can translate into treatment solutions as well as data that can be evaluated on a member and CCO level. Funds from the grant can also be used to acquire telecommunication equipment based on the needs of the CMHP and the members to whom it renders care. EOCCO expressed that tele-behavioral care has demonstrated its ability to increase access and quality of care and, in some settings, to do so more effectively than treatment delivered in person.

The CCO provided a comprehensive description and supporting documentation that demonstrated its MOUs and relationships with APD, Yellowhawk Tribal Health Center, and the local public health and MH authority in each of the 12 EOCCO counties within the CCO contracted geographic service area. Each of the above-mentioned stakeholders had representation at the CCO's local and regional CAC meetings. Additionally, the CCO had various collaborative initiatives with the stakeholders that ranged from multi-disciplinary teams (MDTs), COVID-19 pandemic support and resources for those living in rural areas, funding support to establish sustainable and beneficial community programs, and partnering to provide training in rural Oregon to improve care for persons with disabilities and aging. For example, EOCCO's members with extreme complex care coordination needs could be referred to MDT by internal CCO staff; APD staff; or any member of the medical community such as physicians, nurses, discharge planners, and CHWs. The CCO CM leadership met regularly with MDTs to determine next steps, assign the appropriate staff to follow-up, and document the plan. EOCCO found that this type of collaboration level reduces the time and redundancy of case research and resources.

Table B-9 provides the complete EOCCO DSN Provider Narrative Report evaluation results.

Table B-9—EOCCO—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0.5	**Findings**: EOCCO's narrative response referenced a policy and procedures that described using Quest Analytics Enterprise Services to perform geocoding and mapping for time/distance analysis and compare its current membership ZIP Code census against its provider network; however, using the membership ZIP Code census to conduct analysis instead of incorporating the entire physical addresses of the members and the providers as the data points produces an estimate instead of an accurate calculation of the routine travel time and distance. **Recommendation for the Next Submission:** EOCCO should incorporate the entire physical addresses of all members and providers to establish data points when calculating routine time, distance, and overall member access standards.
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	0.5	**Findings**: EOCCO's narrative response referenced a policy and procedures that described using Quest Analytics Enterprise Services to perform geocoding and mapping for time/distance

	Category Elements	Score	Findings/Recommendations
	efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.		analysis and compare its current membership ZIP Code census against its provider network; however, using the membership ZIP Code census to conduct analysis instead of incorporating the entire physical addresses of the members and the specialty providers as the data points produces an estimate instead of an accurate calculation of the routine travel time and distance. **Recommendation for the Next Submission:** EOCCO should incorporate the entire physical addresses of all members and specialty providers to establish data points when calculating routine time, distance, and overall member access standards.
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's narrative response described its methodology and calculations for the ratio of members to PCPs; specialists; and MH, SUD, and oral health providers for one of its four delegated DCOs. However, the CCO's response did not include the member-to-provider ratios for all oral health providers and availability of acute care beds within its DSN. **Recommendation for the Next Submission:** EOCCO should address the member-to-provider ratios for all oral health providers and availability of acute care beds within its DSN.
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

Category Elements		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.	0.5	**Findings**: EOCCO's narrative response described the availability and access that members have to alternative therapy providers. Additionally, the CCO's response was accompanied with analytics to demonstrate the provider count across each county and across its geographic service area; however, the CCO did not specifically address whether the available services are considered adequate to meet the needs of its membership. **Recommendation for the Next Submission:** EOCCO should address whether the available services are considered adequate to meet the needs of its membership.
	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.	1	Met

	Category Elements	Score	Findings/Recommendations
	• 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.		
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 surveys; and Consumer Assessment of Healthcare Providers and Systems (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**

Category Elements		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**

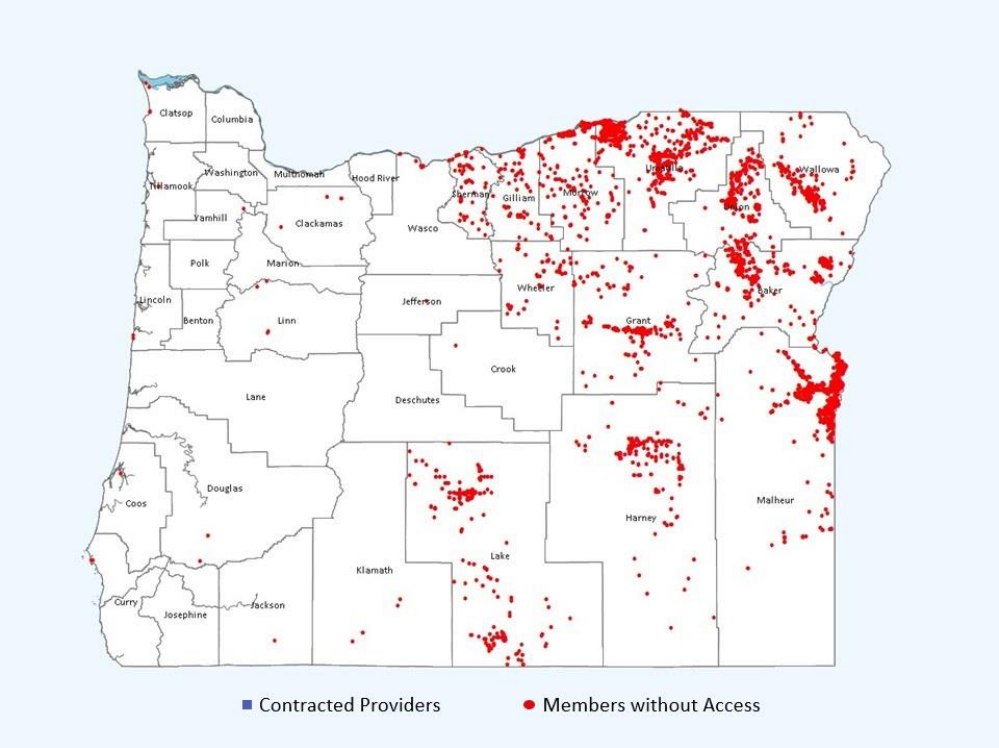
DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of EOCCO's network of individual practitioners and facility/business/service providers to its total membership was sufficient to cover most of the CCO's service area (i.e., Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler counties) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards, except for some member access to pediatric individual practitioners across all 12 counties.

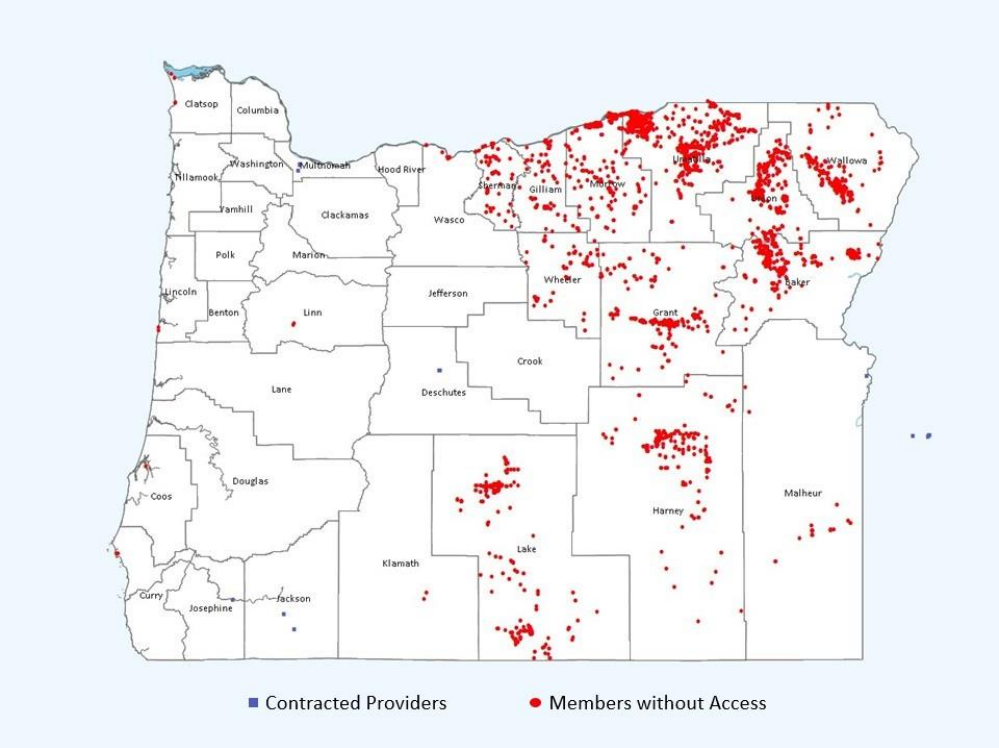
All of the ZIP Codes within EOCCO's service area are classified as rural. As shown below in Figure B-6, the graphic representation illustrates pediatric members residing in rural areas without access to SUD pediatric practitioners within EOCCO's service area. HSAG's analysis identified no SUD pediatric practitioners. All 25,280 (100 percent) pediatric members were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of EOCCO's service area.

Figure B-6—EOCCO—Rural Members Without Access to SUD Pediatric Practitioners



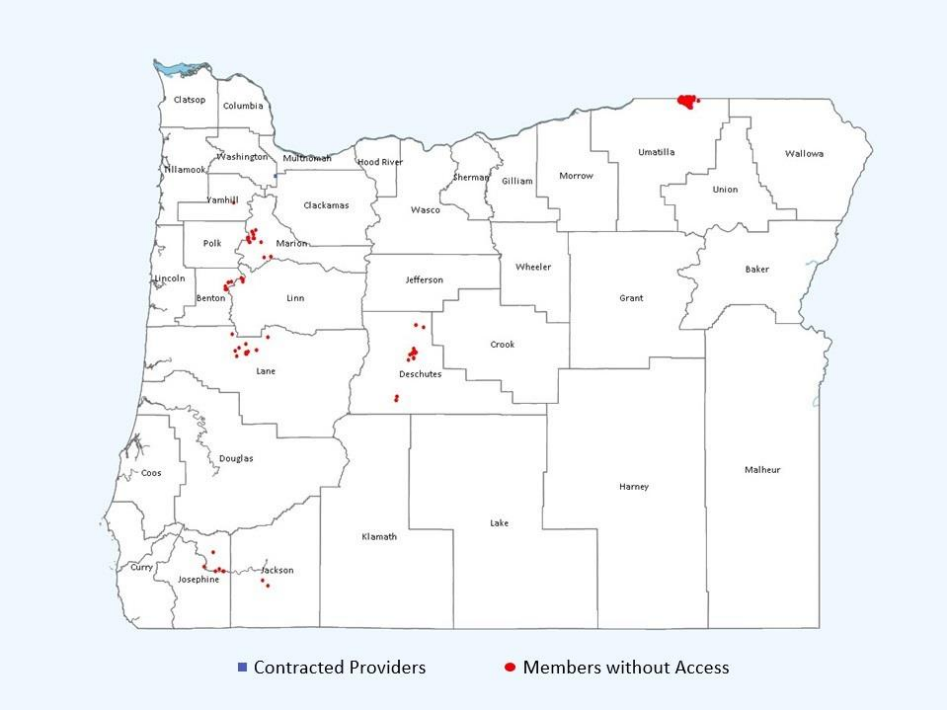
As shown below in Figure B-7, the graphic representation illustrates pediatric members residing in rural areas without access to specialty pediatric practitioners within EOCCO's service area. HSAG's analysis identified an aggregated count of 94 specialty pediatric practitioners at 22 locations. Of the 25,280 EOCCO pediatric members, 19,449 (76.9 percent) were without access within 60 miles/minutes in the CCO's service area.

Figure B-7—EOCCO—Rural Members Without Access to Specialty Pediatric Practitioners



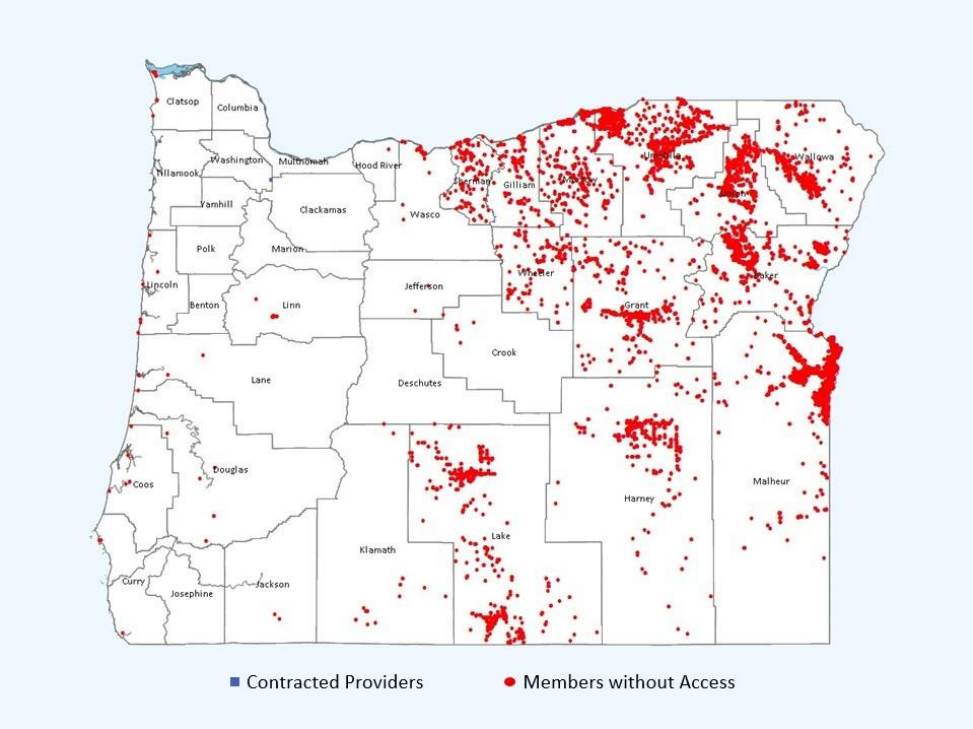
As shown below in Figure B-8, the graphic representation illustrates members residing in urban areas without access to Pharmacies within EOCCO's service area. HSAG's analysis identified an aggregated count of five pharmacies. Of the 3,495 EOCCO members, 3,443 (98.5 percent) were without access within 30 miles/minutes in the CCO's service area.

Figure B-8—EOCCO—Urban Members Without Access to Pharmacies



As shown below in Figure B-9, the graphic representation illustrates members residing in rural areas without access to a Pharmacy within EOCCO's service area. HSAG's analysis identified an aggregated count of five pharmacies. Of the 54,248 EOCCO members, 54,225 (99.9 percent) were without access within 60 miles/minutes in the CCO's service area.

Figure B-9—EOCCO—Rural Members Without Access to Pharmacies



Provider Network Quality and Count Results

EOCCO submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was fair with a few data quality issues. The following area of concern was observed in EOCCO's report:

- Of the individual practitioner data records submitted, only 85.4 percent of the providers had Credentialing Date data field values populated, and only 92.4 percent of those were valid values.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 6,120 individual practitioner and 214 facility/business/service provider data records of contracted providers. Table B-10 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of EOCCO's DSN Provider Capacity Report submission:

- Of the 6,120 total counted individual practitioners, 1,489 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 115 in Baker County, 12 in Gilliam County, 77 in Grant County, 76 in Harney County, 54 in Lake County, 265 in Malheur

County, 103 in Morrow County, five in Sherman County, 430 in Umatilla County, 254 in Union County, 84 in Wallowa County, 11 in Wheeler County, and the three remaining in a county that does not border the CCO's service area.

- Of the 214 total counted facility/business/service providers, 52 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 49 in the 12 counties in the CCO's service area and the remaining three in a non-bordering county.
- No Health Education, Health Promotion, Health Literacy or Palliative Care individual practitioner data records were populated.
- No Ambulance and Emergency Medical Transportation, Indian Health Service and Tribal Health Services, MH Crisis Services, or Community Prevention Services facility/business/service provider data records were populated.
- One Certified or Qualified Health Care Interpreters data record was populated; however, it was not identified as a contracted and in-network provider.
- One Non-Emergent Medical Transportation data record was populated; however, it was not identified as a contracted and in-network provider.
- One Pharmacies data record was populated; however, it was not identified as a contracted and in-network provider.
- Of the 35 total counted Traditional Health Workers data records, seven were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining 28 contracted and out-of-network data records, none of the providers were identified as speaking a non-English language.
- Of the Specialty Provider individual practitioner data records identified as contracted and in-network providers, only one data record was identified as a pediatric provider.

Table B-10—Individual Practitioner and Facility/Business/Service Provider Counts for EOCOO

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	985	16.1%	289	19.4%	696	15.0%
Specialty Provider	2,956	48.3%	542	36.4%	2,414	52.1%
Oral Health Provider	318	5.2%	183	12.3%	135	2.9%
MH Provider	1,339	21.9%	391	26.3%	948	20.5%
SUD Provider	486	7.9%	77	5.2%	409	8.8%
Certified or Qualified Health Care Interpreters	1	<0.1%	0	0.0%	1	<0.1%
Traditional Health Workers	35	0.6%	7	0.5%	28	0.6%
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**6,120**	**100.0%**	**1,489**	**100.0%**	**4,631**	**100.0%**

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	1	0.5%	1	1.9%	0	0.0%
Ambulance and Emergency Medical Transportation	0	0.0%	0	0.0%	0	0.0%
Federally Qualified Health Centers	4	1.9%	4	7.7%	0	0.0%
Home Health	5	2.3%	2	3.8%	3	1.9%
Hospice	6	2.8%	1	1.9%	5	3.1%
Hospital	52	24.3%	17	32.7%	35	21.6%
Imaging	10	4.7%	5	9.6%	5	3.1%
Indian Health Service and Tribal Health Services	0	0.0%	0	0.0%	0	0.0%
MH Crisis Services	0	0.0%	0	0.0%	0	0.0%
Community Prevention Services	0	0.0%	0	0.0%	0	0.0%
Non-Emergent Medical Transportation	1	0.5%	0	0.0%	1	0.6%
Pharmacies	1	0.5%	0	0.0%	1	0.6%
Durable Medical Providers	84	39.3%	8	15.4%	76	46.9%
Post-hospital Skilled Nursing Facility	39	18.2%	6	11.5%	33	20.4%
Rural Health Centers	8	3.7%	6	11.5%	2	1.2%
School-based Health Centers	1	0.5%	1	1.9%	0	0.0%
Urgent Care Center	2	0.9%	1	1.9%	1	0.6%
Overall	**214**	**100.0%**	**52**	**100.0%**	**162**	**100.0%**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Health Share of Oregon

DSN Provider Narrative Evaluation Results

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

The CCO submitted a DSN Provider Narrative Report with comprehensive and detailed responses, accompanied with policies, data dashboards, analytics, committee charters, and other supporting documentation to further demonstrate DSN-related monitoring and oversight mechanisms.

Health Share described using various data resources and monitoring activities to ascertain the availability of covered services available to its membership. For example, the CCO generated capacity reports weekly by physical and dental health delegated subcontractor and county, analyzing accessibility and distribution to ensure that it continues to be sufficient to meet the needs of Health Share members. Additionally, at minimum, the CCO monitored provider-to-member ratios, appointment availability results, produced time and distance geo-maps, and the percentage of contracted providers accepting new members. For instance, the CCO reviewed and discussed the maps, internal network analysis, and oversight of delegated DSN reporting quarterly. Health Share reported conducting an annual evaluation of member-to-provider ratios and travel time and distance annually in conjunction with the DSN reporting activity. Health Share's delegated physical, oral, and BH subcontractors were responsible for developing and implementing an access plan that included a reporting system, monitoring activities to ensure member access to all covered services, conducting an analysis to determine provider capacity, and generating required reports in alignment with the frequency identified by Health Share.

Health Share reported leveraging grievance, complaint, and CAHPS survey data to monitor access and member satisfaction. Specifically, each delegated subcontractor was required to submit quarterly data to Health Share for analyzing. The aggregated analysis was analyzed for patterns in grievance by type of plan, unique delegated subcontractors, provider type, service type, and the corresponding category of grievance. Analysis results were reported to the CCO's Quality and Health Outcomes Committee of the Boards and the individual delegated subcontractors. Health Share's narrative response included several examples to further demonstrate how member feedback was incorporated into network adequacy decisions. For example, one delegated physical health subcontractor observed an increase in member complaints related to specialty care access. In response to this trend, an access coordinator position was implemented to develop and strengthen relationships between the member's PCP and specialists. This position also worked with the member to identify and address any barriers to the member's ability to make the appointment, such as transportation and interpretation service. Analysis of the impact of this new role indicated a 98 percent show rate for members referred to orthopedic and neurology appointments.

Health Share detailed various processes, mechanisms, and partnerships in place to identify and assess members for special health care needs. Once a member had been identified as having special health care needs, a more comprehensive assessment was completed by a care coordinator. The member's

assessment information such as gaps in care, medication adherence, and condition management were used by the care coordinator to form an interdisciplinary care team with the most appropriate team participants for the development, implementation, and achievement of a plan of care. In addition to identifying special health care needs through assessments, the CCO used Health Share's Bridge, an electronic data warehouse and data delivery solution that allows behavioral, dental, clinical, claims, pharmacy, and known chronic conditions data to be integrated and stratified to predict member risk and CM functions. The CCO's narrative response included several scenarios and examples of how identified special health care needs are used to develop programs and initiatives, to improve member coordination of care.

Table B-11 provides the complete Health Share DSN Provider Narrative Report evaluation results.

Table B-11—Health Share—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0.5	**Findings**: Health Share's narrative response discussed and demonstrated how its network ensures time and distance standards for member access to health care providers are met; however, the reported routine travel time and distance standards were based on plotting a central point, such as Portland, and including all members within the 30 minute/mile or 60 minute/mile radius as having access, instead of geocoding the full addresses. **Recommendation for the Next Submission:** Health Share should incorporate the entire physical addresses of all members and providers to establish data points when calculating routine time, distance, and overall member access standards.
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**: Health Share's narrative response discussed and demonstrated how its network ensures time and distance standards for member access to specialty care providers are met; however, the reported routine travel time and distance

Category Elements		Score	Findings/Recommendations
			standards were based on plotting a central point, such as Portland, and including all members within the 30 minute/mile or 60 minute/mile radius as having access, instead of geocoding the full addresses **Recommendation for the Next Submission:** Health Share should incorporate the entire physical addresses of all members and providers to establish data points when calculating routine time, distance, and overall member access standards.
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
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),	1	Met

	Category Elements	Score	Findings/Recommendations
	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.	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	**11.0**	**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)	1	Met

Category Elements		Score	Findings/Recommendations
	mental health surveys; and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CCO needs to 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
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

Category Elements		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**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of Health Share's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Clackamas County, Multnomah County, and Washington County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards. The ZIP Codes within Health Share's service areas represent a mix of urban and rural areas. No deficiencies were assessed, validating that 90 percent of Health Share's adult and pediatric members had access to all required provider service categories.

Provider Network Quality and Count Results

Health Share submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was excellent with no notable data quality issues.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 23,480 individual practitioner and 1,497 facility/business/service provider data records of contracted providers. Table B-12 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of Health Share's DSN Provider Capacity Report submission:

- Of the 23,480 total counted individual practitioners, 18,868 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 3,349 in Clackamas County, 10,228 in Multnomah County, 5,289 in Washington County, and the remaining two in the bordering counties of Columbia and Yamhill.
- Of the 1,497 total counted facility/business/service providers, 1,296 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 699 located across the three counties in the CCO's service area, 150 in counties that border the service area, and the remaining 447 in counties across the rest of the state.
- No Certified or Qualified Health Care Interpreters; Health Education, Health Promotion, Health Literacy; or Palliative Care individual practitioner data records were populated.
- Two Indian Health Service and Tribal Health Services data records were populated; however, none were identified as contracted and in-network providers.
- Of the 18 total counted Traditional Health Workers data records, 12 were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining six contracted and out-of-network Traditional Health Workers data records, none of the providers were identified as speaking a non-English language.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-12—Individual Practitioner and Facility/Business/Service Provider Counts for Health Share

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	7,085	30.2%	5,388	28.6%	1,697	36.8%
Specialty Provider	12,465	53.1%	10,117	53.6%	2,348	50.9%
Oral Health Provider	1,035	4.4%	992	5.3%	43	0.9%
MH Provider	2,291	9.8%	1,922	10.2%	369	8.0%
SUD Provider	586	2.5%	437	2.3%	149	3.2%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%	0	0.0%
Traditional Health Workers	18	0.1%	12	0.1%	6	0.1%
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**23,480**	**100.0%**	**18,868**	**100.0%**	**4,612**	**100.0%**
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	45	3.0%	23	1.8%	22	11.1%
Ambulance and Emergency Medical Transportation	11	0.7%	5	0.4%	6	3.0%
Federally Qualified Health Centers	53	3.5%	30	2.3%	23	11.6%
Home Health	42	2.8%	23	1.8%	19	9.6%
Hospice	33	2.2%	20	1.5%	13	6.6%
Hospital	78	5.2%	56	4.3%	22	11.1%
Imaging	23	1.5%	20	1.5%	3	1.5%
Indian Health Service and Tribal Health Services	2	0.1%	0	0.0%	2	1.0%
MH Crisis Services	1	0.1%	1	0.1%	0	0.0%
Community Prevention Services	10	0.7%	7	0.5%	3	1.5%
Non-Emergent Medical Transportation	1	0.1%	1	0.1%	0	0.0%
Pharmacies	693	46.3%	690	53.2%	0	0.0%
Durable Medical Providers	324	21.6%	324	25.0%	0	0.0%
Post-hospital Skilled Nursing Facility	105	7.0%	54	4.2%	51	25.8%
Rural Health Centers	28	1.9%	7	0.5%	21	10.6%
School-based Health Centers	2	0.1%	2	0.2%	0	0.0%
Urgent Care Center	46	3.1%	33	2.5%	13	6.6%
Overall	**1,497**	**100.0%**	**1,296**	**100.0%**	**198**	**100.0%**

[1] Limited to providers in Oregon.

[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

InterCommunity Health Network

DSN Provider Narrative Evaluation Results

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

The CCO submitted a DSN Provider Narrative Report with detailed responses, accompanied with policies, processes, workflows, data dashboards, and analytics to further demonstrate DSN-related monitoring and oversight mechanisms. Not all IHN's supporting documentation was referenced in its narrative response. In one narrative response, the CCO referenced the "2020 MM Plan," but no document by this title was included in IHN's submission.

IHN described the metric-based contracts established with six community-based organizations that employ THWs. The CCO conducted quarterly meetings with each organization to review performance metrics, assess the value of services, and evaluate target influences for cost and outcomes. The CCO also monitored and trended member calls to its customer service and medical management departments that result in referrals to the contracted THWs. Analysis of member calls determined a need for Spanish-speaking doulas. Through the THW Workgroup, a component of IHN's collaborative Delivery System Transformation Committee, a proposal to fund, recruit, train, and certify Spanish-speaking doulas was submitted and actualized. IHN further detailed that since 2016, an additional funded pilot program, the THW Training Hub, had held over 25 THW trainings across Linn, Benton, and Lincoln counties, with approximately 350 THWs trained. Ninety THWs are credentialed and employed through the five community-based organizations.

In 2019, IHN conducted an assessment of internal and external resources available to promote cultural and linguistic competency within its organization and provider network. The results were used to lay the foundation for the CCO's strategic plan and implementation of applicable policies and procedures. IHN also partnered with the Linn Benton Health Equity Alliance and other community partners to increase awareness and improve access to culturally and linguistically appropriate care and services. The CCO conducted trainings, which focused on unintentional bias and diversity in health care, cultural competency, health literacy, and interpreter services for its executive leadership, employees, and providers annually.

IHN described leveraging its multiple pay-for-performance agreements with its PCPCH clinics, county MH departments, DCO, THW contractors, and a few specialty providers to improve its metric performance and creating more efficient workflows to enhance member access and availability. For example, IHN funded a pilot program to address ED utilization rates. The Homelessness Response Team consisted of THWs and community-based organizations, working directly with local EDs, providing education on how to navigate the health care system, wraparound care, and coordination of services for members that show up to the emergency room. One of IHN's goals for the program is to promote members receiving the right service, at the right time.

Table B-13 provides the complete IHN DSN Provider Narrative Report evaluation results.

Table B-13—IHN—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0.5	**Findings**: IHN's narrative response, submitted policy, and network adequacy analysis described and demonstrated the geographic distribution of PCPs, specialists, MH/BH, SUD, PCPCHs, hospitals, and pharmacies compared with the geographic distributions of members; however, the CCO did not submit geocoding analysis to demonstrate geographic distribution of oral health providers compared to the geographic distribution of members. **Recommendation for the Next Submission:** IHN should submit geocoding analysis to demonstrate geographic distribution of oral health providers compared to the geographic distribution of members.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0.5	**Findings**: IHN's narrative response, submitted policy, and network adequacy analysis described and demonstrated how the CCO ensured time and distance standards for PCPs, specialists, MH/BH, SUD, PCPCHs, hospitals, and pharmacies; however, the CCO did not submit time and distance standards (minutes, miles, and percent of overall member access) for oral health providers. **Recommendation for the Next Submission:** IHN should submit a time and distance analysis (minutes, miles, and percent of overall member access) demonstrating standards for member access to oral health providers are 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.	0.5	**Findings**: IHN's narrative response and Triage and Crisis Services policy outlined that the CCO's clinically trained medical management staff members manage a 24-hour, 7 days a week Nurse Advice Line available to members for triage and referrals to the appropriate level of care for physical, oral, and

Category Elements		Score	Findings/Recommendations
			MH services and the CCO contracts with a CMHP to provide a 24-hour, 7 days a week MH mobile crisis hotline and intervention services; however, the CCO did not address how it monitors, analyzes, or determines if these activities are adequate or not. **Recommendation for the Next Submission:** IHN should address how it monitors, analyzes, and determines if member access to urgent, emergency, crisis, and triage services 24 hours a day/7 days a week is adequate.
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**: IHN's narrative response and submitted policy described the procedures for DSN network adequacy reporting and how identified deficiencies will be addressed; however, the CCO did not described how the data are analyzed and whether member access to specialty care is sufficient for members to receive timely access to care. **Recommendation for the Next Submission:** IHN should described how the data are analyzed and whether member access to specialty care is sufficient for members to receive timely access to care.
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

Category Elements		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	**10.0**	**Out of Possible 12.0**

Category Elements		Score	Findings/Recommendations
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's narrative response described its process for analyzing data and taking into account member characteristics when assigning members to the most appropriate provider that will meet their needs; however, the CCO did not submit analysis to demonstrate the cultural, language, disability, and special health care needs that characterize the CCO's membership. **Recommendation for the Next Submission:** IHN should submit analysis to demonstrate the cultural, language, disability, and special health care needs that characterize the CCO's membership.
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 surveys; and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CCO needs to describe how it uses the input from its community advisory council.	0.5	**Findings**: IHN's narrative response described how member feedback in the form of complaints and grievances is analyzed; however, the CCO did not incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate how it incorporates member feedback into network adequacy decisions. **Recommendation for the Next Submission:** IHN should incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate how it incorporates member feedback into network adequacy decisions.

Category Elements		Score	Findings/Recommendations
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**: IHN's narrative response described how its case managers are trained to ensure appropriate, timely, effective and continuous person-centered care that engages members in taking charge of their health, improving health outcomes, and maintaining the highest level of function; however, the CCO did not incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate how members receive follow-up and training in self-care and other interventions to promote their own health. **Recommendation for the Next Submission:** IHN should incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate how members receive follow-up and training in self-care and other interventions 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**

Category Elements		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.	0.5	**Findings**: IHN's narrative response described how the CCO uses interdisciplinary care teams to coordinate services across the continuum of its members' care and its process for analyzing the impact these teams have on reducing hospital admissions and ED usage; however, the CCO did not address how it determines if care coordinated by interdisciplinary care teams is adequate to reduce hospital readmission and emergency room visits and whether the efforts are adequate. **Recommendation for the Next Submission:** IHN should address how it determines if care coordinated by interdisciplinary care teams is adequate to reduce hospital readmission and emergency room visits and whether the efforts are adequate.
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**: IHN's narrative response described how it uses extracted data from its EHR to identify gaps in preventive and chronic care; however, the CCO did not specifically describe the EHR system/application used by the CCO to coordinate member care.

Category Elements		Score	Findings/Recommendations
			Recommendation for the Next Submission: IHN should describe the EHR system/application used by the CCO to coordinate member care.
	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**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of IHN's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Benton County, Lincoln County, and Linn County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards. Most of the ZIP Codes within IHN's service area are classified as rural with the exception of the areas surrounding Corvallis/Philomath and Albany. No deficiencies were assessed, validating that 90 percent of IHN's adult and pediatric members had access to all required provider service categories.

Provider Network Quality and Count Results

IHN submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was good with a few data quality issues. The following area of concern was observed in IHN's report:

- Of the individual practitioner data records submitted, only 72.2 percent of the providers had the Credentialing Date data field values populated. Of those, only 57.4 percent were valid values.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 10,153 individual practitioner and 888 facility/business/service provider data records of contracted providers. Table B-14 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of IHN's DSN Provider Capacity Report submission:

- Of the 10,153 total counted individual practitioners, 2,750 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 1,220 in Benton County, 618 in Lincoln County, and 912 in Linn County.
- Of the 888 total counted facility/business/service providers, 117 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 36 in Benton County, 33 in Lincoln County, and 48 in Linn County.
- No Certified or Qualified Health Care Interpreters; Health Education, Health Promotion, Health Literacy; or Palliative Care individual practitioner data records were populated.
- No Hospital, Acute Psychiatric Care; Ambulance and Emergency Medical Transportation; Indian Health Service and Tribal Health Services; MH Crisis Services; Community Prevention Services; or School-based Health Centers facility/business/service provider data records were populated.
- Of the 264 total counted SUD Provider data records, 116 were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining 148 contracted and out-of-network data records, none of the providers were identified as speaking a non-English language.

- Of the 70 total counted Traditional Health Workers data records, 58 were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining 12 contracted and out-of-network Traditional Health Workers data records, none of the providers were identified as speaking a non-English language.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-14—Individual Practitioner and Facility/Business/Service Provider Counts for IHN

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	276	2.7%	223	8.1%	53	0.7%
Specialty Provider	8,101	79.8%	1,633	59.4%	6,468	87.4%
Oral Health Provider	252	2.5%	187	6.8%	65	0.9%
MH Provider	1,190	11.7%	533	19.4%	657	8.9%
SUD Provider	264	2.6%	116	4.2%	148	2.0%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%	0	0.0%
Traditional Health Workers	70	0.7%	58	2.1%	12	0.2%
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**10,153**	**100.0%**	**2,750**	**100.0%**	**7,403**	**100.0%**
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	0	0.0%	0	0.0%	0	0.0%
Ambulance and Emergency Medical Transportation	0	0.0%	0	0.0%	0	0.0%
Federally Qualified Health Centers	9	1.0%	8	6.8%	1	0.1%
Home Health	14	1.6%	6	5.1%	8	1.0%
Hospice	7	0.8%	3	2.6%	4	0.5%
Hospital	34	3.8%	9	7.7%	25	3.2%
Imaging	8	0.9%	2	1.7%	6	0.8%
Indian Health Service and Tribal Health Services	0	0.0%	0	0.0%	0	0.0%
MH Crisis Services	0	0.0%	0	0.0%	0	0.0%
Community Prevention Services	0	0.0%	0	0.0%	0	0.0%
Non-Emergent Medical Transportation	1	0.1%	1	0.9%	0	0.0%
Pharmacies	683	76.9%	50	42.7%	633	82.1%
Durable Medical Providers	97	10.9%	22	18.8%	75	9.7%

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Post-hospital Skilled Nursing Facility	19	2.1%	7	6.0%	12	1.6%
Rural Health Centers	3	0.3%	3	2.6%	0	0.0%
School-based Health Centers	0	0.0%	0	0.0%	0	0.0%
Urgent Care Center	13	1.5%	6	5.1%	7	0.9%
Overall	**888**	**100.0%**	**117**	**100.0%**	**771**	**100.0%**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Jackson Care Connect

DSN Provider Narrative Evaluation Results

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

The CCO submitted a DSN Provider Narrative Report with comprehensive and detailed responses, accompanied with policies, processes, workflows, data dashboards, and analytics to further demonstrate DSN-related monitoring and oversight mechanisms.

JCC reported historically using telemedicine services to eliminate barriers to care and improve member access. The CCO described a barrier to expansion due to the providers' lack of awareness and confidence in using it as a viable alternative to in-person care. As a result of COVID-19, the need for telemedicine services escalated. JCC aligned with OHA and CMS, expanding the provider specialty types that would receive reimbursement for services rendered via phone video conference and email consultations. CareOregon, JCC's administrator, created a public website for its providers to obtain telehealth support and resources. The website is maintained to ensure that updates occur regularly.

The CCO demonstrated established relationships and MOUs with APD, local public health authority, local MH authority, and IHS/Tribal health clinics. Through CareOregon, JCC's OHP administrator, a Tribal Health Care Coordination Program was developed, and a care coordination contract was implemented to engage American Indians and Alaskan Natives with access to and navigation of health care services in a culturally responsive manner. The program's tribal liaison played an essential role to ensure transparent and consistent communication, support, and engagement between the CCO and Tribal Health Partners.

JCC identified that well-child visits and childhood/adolescent vaccination performance metrics declined as a result of COVID-related utilization patterns. The CCO took a multi-pronged approach to improve and increase its metric performance, which included expanding capacity. For example, JCC recruited and contracted with PCPs to expand its PCPCH threshold. The CCO's efforts also targeted providers participating in the Vaccines for Children (VFC) program to expand access to immunization. JCC also described its member outreach initiative. The CCO submitted its data scrubbing instructions and outreach workflow to demonstrate the processes and procedures conducted to improve metrics performing below the baseline.

Table B-15 provides the complete JCC DSN Provider Narrative Report evaluation results.

Table B-15—JCC—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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

Category Elements		Score	Findings/Recommendations
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	**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

Category Elements		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 surveys; and Consumer Assessment of Healthcare Providers and Systems (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**

Category Elements		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**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of JCC's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Jackson County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards. Most of the ZIP Codes within JCC's service area (i.e., Jackson County) are classified as rural except for areas associated with Medford and Phoenix/Talent, Oregon. No deficiencies were assessed, validating that 90 percent of JCC's adult and pediatric members had access to all required provider service categories.

Provider Network Quality and Count Results

JCC submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was excellent with no notable data quality issues.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 13,237 individual practitioner and 884 facility/business/service provider data records of contracted providers. Table B-16 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of JCC's DSN Provider Capacity Report submission:

- Of the 13,237 total counted individual practitioners, 1,404 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 1,378 in Jackson County and the remaining 26 in Josephine County, which borders the CCO's service area.
- Of the 888 total counted facility/business/service providers, 76 data records were identified as contracted and in-network providers. All 76 data records were providers in Jackson County.
- No Certified or Qualified Health Care Interpreters; Health Education, Health Promotion, Health Literacy; or Palliative Care individual practitioner data records were populated.
- No Imaging, MH Crisis Services, or Community Prevention Services facility/business/service provider data records were populated.
- Three Hospital, Acute Psychiatric Care data records were populated; however, neither was identified as a contracted and in-network provider.
- Two Indian Health Service and Tribal Health Services data records were populated; however, neither was identified as a contracted and in-network provider.
- Seven Rural Health Centers data records were populated; however, none were identified as contracted and in-network providers.
- Two School-based Health Centers data records were populated; however, neither was identified as a contracted and in-network provider.

- Of the 73 total counted Traditional Health Workers data records, 23 were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining 50 contracted and out-of-network Traditional Health Workers data records, none of the providers were identified as speaking a non-English language.
- Of the 370 total counted SUD Provider data records, 73 were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining 297 contracted and out-of-network SUD Providers data records, five of the providers were identified as speaking a non-English language.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-16—Individual Practitioner and Facility/Business/Service Provider Counts for JCC

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	6,240	47.1%	571	40.7%	5,669	47.9%
Specialty Provider	5,167	39.0%	416	29.6%	4,751	40.2%
Oral Health Provider	159	1.2%	134	9.5%	25	0.2%
MH Provider	1,228	9.3%	187	13.3%	1,041	8.8%
SUD Provider	370	2.8%	73	5.2%	297	2.5%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%	0	0.0%
Traditional Health Workers	73	0.6%	23	1.6%	50	0.4%
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**13,237**	**100.0%**	**1,404**	**100.0%**	**11,833**	**100.0%**
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	3	0.3%	0	0.0%	3	0.4%
Ambulance and Emergency Medical Transportation	4	0.5%	1	1.3%	3	0.4%
Federally Qualified Health Centers	23	2.6%	6	7.9%	17	2.1%
Home Health	20	2.3%	3	3.9%	17	2.1%
Hospice	12	1.4%	2	2.6%	10	1.2%
Hospital	41	4.6%	6	7.9%	35	4.3%
Imaging	0	0.0%	0	0.0%	0	0.0%
Indian Health Service and Tribal Health Services	2	0.2%	0	0.0%	2	0.2%
MH Crisis Services	0	0.0%	0	0.0%	0	0.0%
Community Prevention Services	0	0.0%	0	0.0%	0	0.0%

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Non-Emergent Medical Transportation	1	0.1%	1	1.3%	0	0.0%
Pharmacies	550	62.2%	35	46.1%	515	63.7%
Durable Medical Providers	84	9.5%	14	18.4%	70	8.7%
Post-hospital Skilled Nursing Facility	89	10.1%	5	6.6%	84	10.4%
Rural Health Centers	7	0.8%	0	0.0%	7	0.9%
School-based Health Centers	2	0.2%	0	0.0%	2	0.2%
Urgent Care Center	46	5.2%	3	3.9%	43	5.3%
Overall	**884**	**100.0%**	**76**	**100.0%**	**808**	**100.0%**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

PacificSource Community Solutions–Central Oregon

DSN Provider Narrative Evaluation Results

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

The CCO submitted a DSN Provider Narrative Report with comprehensive and detailed responses, accompanied with policies, desktop procedures, data dashboards, analytics, and other supporting documentation to further demonstrate DSN-related monitoring and oversight mechanisms.

PSCS-CO provided a thorough description of its geocoding software, a detailed qualitative and quantitative time and distance analysis, and a comparison of the geographic distribution of members to providers; however, the CCO described using both member-level and provider-level ZIP Codes as the data points to conduct its analysis, instead of incorporating the entire physical addresses of the member and the provider. PSCS-CO's analysis demonstrated the CCO's compliance with the time, distance, and overall member access standards, but measuring with a member's ZIP Code or "central point" to the closest provider within the same ZIP Code or "central point" produces an inaccurate estimate of the routine travel time and distance.

The CCO described multiple mechanisms used to incorporate member feedback from CAHPS surveys, health surveys, grievances and complaints, and its CAC into its network adequacy decision making. For instance, the CCO's CAC participated in the development of its Transformation and Quality Strategies (TQS). The CAC voted, offering input on which TQS and other projects should be prioritized. One of the selected TQS was the Medicaid Access to Care Survey, which will measure member experience when accessing care and member satisfaction. PSCS-CO solicitated and applied CAC and member feedback during the development of the survey. The survey was scheduled to be launched in spring 2020; however, due to the impact of COVID-19, PSCS-CO's anticipated tentative launch date is fall 2020. The CCO intends to incorporate the data result with the other adult, family, and child surveys.

PSCS-CO's narrative response described, and the supporting documentation demonstrated, how interdisciplinary care teams are used to coordinate services across the continuum of care. An interdisciplinary care team meeting with participation from the PCP, specialist, clinic care coordinator, member, and the CCO's CM team was conducted to work toward the goal of addressing and reducing the member's ED visits and inpatient admissions. The team identified barriers to care such as limited access to utilities (i.e., water and electricity), which was needed for proper health and self-care; and no wireless access, limiting the member's ability to schedule appointments and participate in telehealth visits. As a result of the meeting and collaborative care planning, the member was furnished with wireless access through the Lifeline Assistance Program and access to running water. PSCS-CO conveyed that the member had not had any ED visits or inpatient admissions since these resources were established.

Table B-17 provides the complete PSCS-CO DSN Provider Narrative Report evaluation results.

Table B-17—PSCS-CO—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0.5	**Findings**: PSCS-CO's narrative response 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:** PSCS-CO should analyze routine time, distance, and overall member access standards by geocoding the members' physical addresses and the physical addresses of the providers.
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**: PSCS-CO's narrative response discussed and demonstrated how its network ensures time and distance standards for member access to specialists; however, the reported routine travel time and distance standards were based on member-level and provider-level ZIP Code data instead of geocoding the full addresses.

Category Elements		Score	Findings/Recommendations
			Recommendation for the Next Submission: PSCS-CO should analyze routine time, distance, and overall member access standards by geocoding the members' physical addresses and the physical addresses of the providers.
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
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

Category Elements		Score	Findings/Recommendations
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	**11.0**	**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 surveys; and Consumer Assessment of Healthcare Providers and Systems (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

Category Elements		Score	Findings/Recommendations
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
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**

Category Elements		Score	Findings/Recommendations
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**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of PSCS-CO's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Crook County, Deschutes County, Jefferson County, and parts of Klamath County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards, except for member access to PCPCH providers.

All of the ZIP codes within PSCS-CO's service area are classified as rural except for the area around Bend, Oregon, which is classified as urban. As shown below in Figure B-10 and Figure B-11, the graphic representations illustrate members without access to PCPCH practitioners and facilities within 30 and 60 miles/minutes. HSAG's analysis identified no PCPCH providers. All 39,893 (100 percent) members residing in urban areas were without access within 30 miles/minutes in the CCO's service area. Likewise, 18,124 (100 percent) members residing in rural areas were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of PSCS-CO's service area.

Figure B-10—PSCS-CO—Urban Members Without Access to PCPCH Practitioners and Facilities

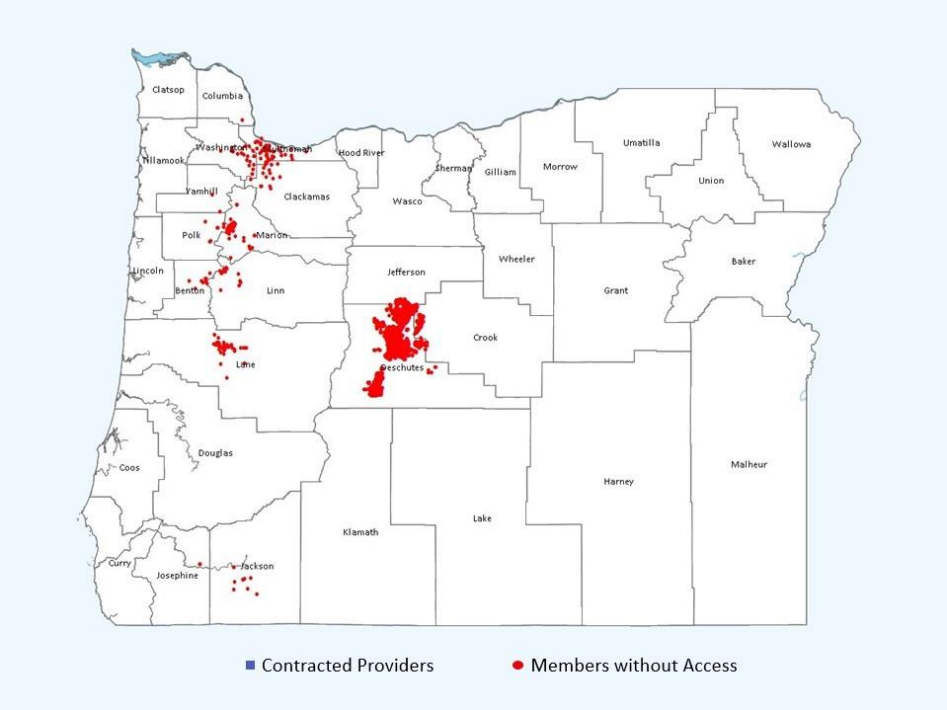
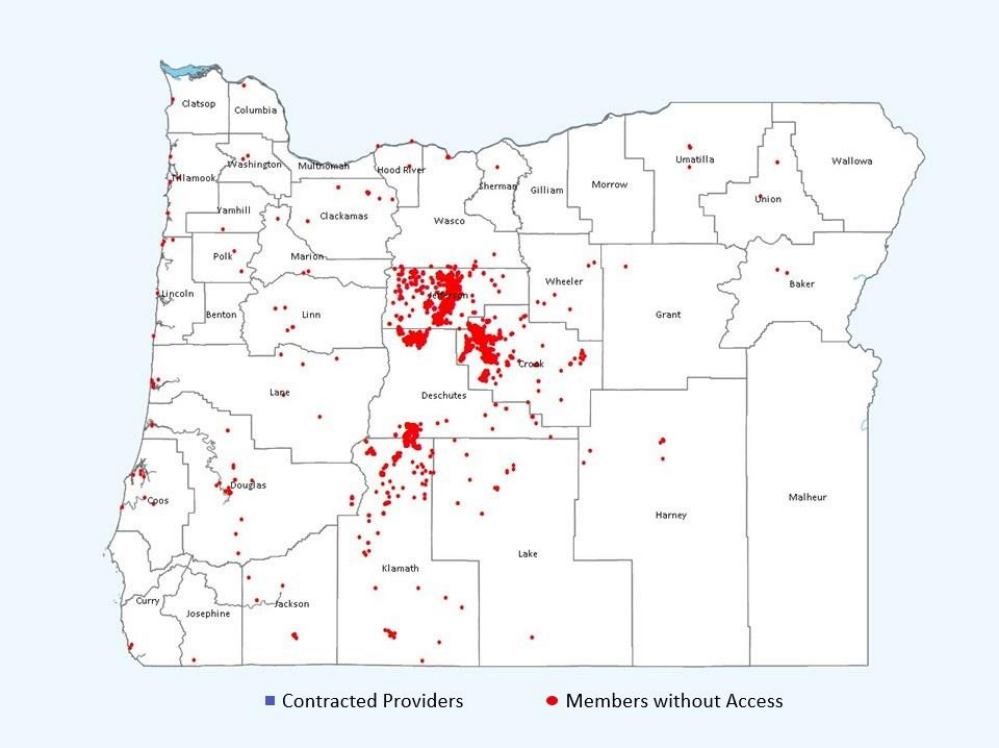


Figure B-11—PSCS-CO—Rural Members Without Access to PCPCH Practitioners and Facilities



Provider Network Quality and Count Results

PSCS-CO submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was excellent with no notable data quality issues.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 17,311 individual practitioner and 1,418 facility/business/service provider data records of contracted providers. Table B-18 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of PSCS-CO's DSN Provider Capacity Report submission:

- Of the 17,311 total counted individual practitioners, 2,307 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 1,819 in Deschutes County, 262 in Crook County, 222 in Jefferson County, two in Klamath County, and the remaining two in Douglas County, which borders one of the counties in the CCO's service area.
- Of the 1,418 total counted facility/business/service providers, 160 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 117 in Deschutes County, 20 in Crook County, 20 in Jefferson County, and three in Klamath County. All data records were located within the CCO's service area.

- No Health Education, Health Promotion, Health Literacy or Palliative Care individual practitioner data records were populated.
- No Non-Emergent Medical Transportation, School-based Health Centers, and Urgent Care Center facility/business/service provider data records were populated.
- Of the 16 total counted Traditional Health Workers data records, four were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining 12 contracted and out-of-network Traditional Health Workers data records, none of the providers were identified as speaking a non-English language.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-18—Individual Practitioner and Facility/Business/Service Provider Counts for PSCS-CO

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	283	1.6%	283	12.3%	0	0.0%
Specialty Provider	12,453	71.9%	1,222	53.0%	11,231	74.9%
Oral Health Provider	829	4.8%	162	7.0%	667	4.4%
MH Provider	3,334	19.3%	574	24.9%	2,760	18.4%
SUD Provider	395	2.3%	61	2.6%	334	2.2%
Certified or Qualified Health Care Interpreters	1	<0.1%	1	<0.1%	0	0.0%
Traditional Health Workers	16	0.1%	4	0.2%	12	0.1%
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**17,311**	**100.0%**	**2,307**	**100.0%**	**15,004**	**100.0%**
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	36	2.5%	5	3.1%	31	2.5%
Ambulance and Emergency Medical Transportation	109	7.7%	19	11.9%	90	7.2%
Federally Qualified Health Centers	20	1.4%	6	3.8%	14	1.1%
Home Health	29	2.0%	3	1.9%	26	2.1%
Hospice	25	1.8%	3	1.9%	22	1.7%
Hospital	73	5.1%	12	7.5%	61	4.8%
Imaging	30	2.1%	7	4.4%	23	1.8%
Indian Health Service and Tribal Health Services	2	0.1%	1	0.6%	1	0.1%
MH Crisis Services	72	5.1%	13	8.1%	59	4.7%
Community Prevention Services	39	2.8%	6	3.8%	33	2.6%

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Non-Emergent Medical Transportation	0	0.0%	0	0.0%	0	0.0%
Pharmacies	655	46.2%	37	23.1%	618	49.1%
Durable Medical Providers	236	16.6%	39	24.4%	197	15.7%
Post-hospital Skilled Nursing Facility	77	5.4%	6	3.8%	71	5.6%
Rural Health Centers	15	1.1%	3	1.9%	12	1.0%
School-based Health Centers	0	0.0%	0	0.0%	0	0.0%
Urgent Care Center	0	0.0%	0	0.0%	0	0.0%
Overall	**1,418**	**100.0%**	**160**	**100.0%**	**1,258**	**100.0%**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

PacificSource Community Solutions–Columbia Gorge

DSN Provider Narrative Evaluation Results

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.

The CCO submitted a DSN Provider Narrative Report with comprehensive and detailed responses, accompanied with policies, desktop procedures, data dashboards, analytics, and other supporting documentation to further demonstrate DSN-related monitoring and oversight mechanisms.

PSCS-CG provided a thorough description of its geocoding software, a detailed qualitative and quantitative time and distance analysis, and a comparison of the geographic distribution of members to providers; however, the CCO described using both member-level and provider-level ZIP Codes as the data points to conduct its analysis, instead of incorporating the entire physical addresses of the member and the provider. PSCS-CG's analysis demonstrated the CCO's compliance with the time, distance, and overall member access standards, but measuring with a member's ZIP Code or "central point" to the closest provider within the same ZIP Code or "central point" produces an inaccurate estimate of the routine travel time and distance.

PSCS-CG's narrative response and supporting documentation thoroughly described and demonstrated the continuum of care for treatment of MH disorders and SUDs. The CCO used the Regional Community Health Assessment findings to evaluate the adequacy of access to services and determine which region's needs should be prioritized. The findings identified that half of the Medicaid members surveyed had a BH diagnosis, of which anxiety is the most common diagnosis. In response to member feedback regarding barriers to MH and SUD care, PSCS-CG hired a system of care coordinators as a collaborative approach to help further identify any barriers and gaps to service in this region and develop system of care governance.

PSCS-CG's performance metric monitoring and analysis identified a trend of below baseline performance related to oral health evaluations. Further investigating pinpointed that diabetic members underutilized these services due to some challenges with access. In an effort to increase performance and reduce barriers to access, PSCS-CG collaborated with both physical health and oral health providers. The physical health office conducted outreach calls to schedule in-person visits with diabetic patients with the intention of using the provider's office as the originating site for teledentistry appointments. The CCO reported that this collaborative approach addresses improved performance and a specific barrier to access.

Table B-19 provides the complete PSCS-CG DSN Provider Narrative Report evaluation results.

Table B-19—PSCS-CG—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0.5	**Findings**: PSCS-CG's narrative response discussed and demonstrated how its network ensures time and distance standards for member access to health care are met; however, the reported routine travel time and distance standards were based on member-level and provider-level ZIP Code data instead of geocoding the full addresses. **Recommendation for the Next Submission:** PSCS-CG should incorporate the entire physical addresses of all members and providers to establish data points when calculating routine time, distance, and overall member access standards.
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**: PSCS-CG's narrative response discussed and demonstrated how its network ensures time and distance standards for member access to specialists; however, the reported routine travel time and distance standards were based on member-level and provider-level ZIP Code data instead of geocoding the full addresses.

Category Elements		Score	Findings/Recommendations
			Recommendation for the Next Submission: PSCS-CG should incorporate the entire physical addresses of all members and providers to establish data points when calculating routine time, distance, and overall member access standards.
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
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

Category Elements		Score	Findings/Recommendations
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	**11.0**	**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 surveys; and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CCO needs to describe how it uses the input from its community advisory council.	1	Met

Category Elements		Score	Findings/Recommendations
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
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met

Category Elements		Score	Findings/Recommendations
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**

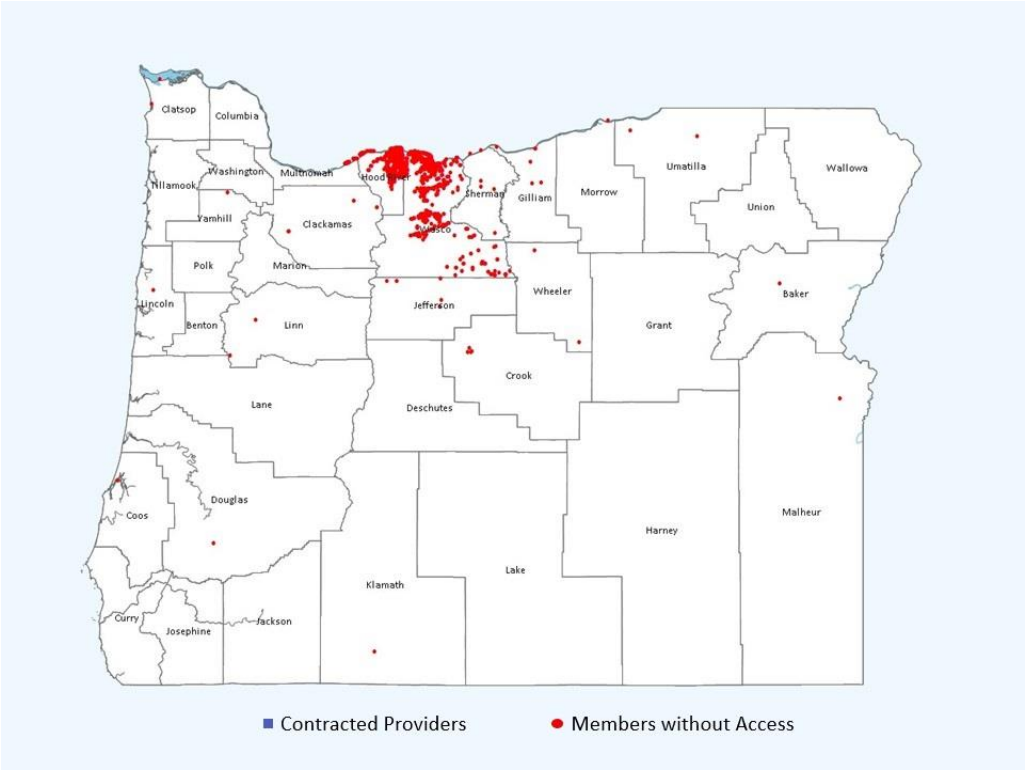
DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of PSCS-CG's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Hood River County and Wasco County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards, except for member access to PCPCH providers.

All of the ZIP Codes within PSCS-CG's service area are classified as rural. As shown below in Figure B-12, the graphic representation illustrates members residing in rural areas without access to PCPCH practitioners and facilities within 60 miles/minutes. HSAG's analysis identified no PCPCH providers. All 13,605 (100 percent) members were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of PSCS-CG's service area.

Figure B-12—PSCS-CG—Rural Members Without Access to PCPCH Practitioners and Facilities



Provider Network Quality and Count Results

PSCS-CG submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was excellent with no notable data quality issues.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 17,291 individual practitioner and 1,418 facility/business/service provider data records of contracted providers. Table B-20 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of PSCS-CG's DSN Provider Capacity Report submission:

- Of the 17,291 total counted individual practitioners, 607 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 276 in Hood River County and 331 in Wasco County.
- Of the 1,418 total counted facility/business/service providers, 50 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 21 in Hood River County and 29 in Wasco County.
- No Health Education, Health Promotion, Health Literacy or Palliative Care individual practitioner data records were populated.
- No Non-Emergent Medical Transportation, School-based Health Centers, and Urgent Care Center facility/business/service provider data records were populated.
- One Certified or Qualified Health Care Interpreters data record was populated; however, it was not identified as a contracted and in-network provider.
- Thirty Imaging data records were populated; however, none were identified as contracted and in-network providers.
- Two Indian Health Service and Tribal Health Services data records were populated; however, none were identified as contracted and in-network providers.
- Of the 395 total counted SUD Provider data records, only six were identified as contracted and in-network providers. Of those six SUD Provider data records, none were also identified as speaking a non-English language.
- Of the 3,335 total counted MH Provider data records, 130 were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining 3,205 contracted and out-of-network providers, 40 were identified as speaking a non-English language.
- Of the 16 total counted Traditional Health Workers data records, none were identified as contracted and in-network providers.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-20—Individual Practitioner and Facility/Business/Service Provider Counts for PSCS-CG

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	89	0.5%	89	14.7%	0	0.0%
Specialty Provider	12,626	73.0%	305	50.2%	12,321	73.8%
Oral Health Provider	829	4.8%	77	12.7%	752	4.5%
MH Provider	3,335	19.3%	130	21.4%	3,205	19.2%
SUD Provider	395	2.3%	6	1.0%	389	2.3%
Certified or Qualified Health Care Interpreters	1	<0.1%	0	0.0%	1	<0.1%
Traditional Health Workers	16	0.1%	0	0.0%	16	0.1%
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**17,291**	**100.0%**	**607**	**100.0%**	**16,684**	**100.0%**
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	36	2.5%	3	6.0%	33	2.4%
Ambulance and Emergency Medical Transportation	109	7.7%	8	16.0%	101	7.4%
Federally Qualified Health Centers	20	1.4%	3	6.0%	17	1.2%
Home Health	29	2.0%	2	4.0%	27	2.0%
Hospice	25	1.8%	2	4.0%	23	1.7%
Hospital	73	5.1%	3	6.0%	70	5.1%
Imaging	30	2.1%	0	0.0%	30	2.2%
Indian Health Service and Tribal Health Services	2	0.1%	0	0.0%	2	0.1%
MH Crisis Services	72	5.1%	2	4.0%	70	5.1%
Community Prevention Services	39	2.8%	2	4.0%	37	2.7%
Non-Emergent Medical Transportation	0	0.0%	0	0.0%	0	0.0%
Pharmacies	655	46.2%	10	20.0%	645	47.1%
Durable Medical Providers	236	16.6%	7	14.0%	229	16.7%
Post-hospital Skilled Nursing Facility	77	5.4%	3	6.0%	74	5.4%
Rural Health Centers	15	1.1%	5	10.0%	10	0.7%
School-based Health Centers	0	0.0%	0	0.0%	0	0.0%
Urgent Care Center	0	0.0%	0	0.0%	0	0.0%
Overall	**1,418**	**100.0%**	**50**	**100.0%**	**1,368**	**100.0%**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

PacificSource Community Solutions–Lane

DSN Provider Narrative Evaluation Results

PacificSource Community Solutions–Lane (PSCS-Lane) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Lane County.

The CCO submitted a DSN Provider Narrative Report with comprehensive and detailed responses, accompanied with policies, desktop procedures, data dashboards, analytics, and other supporting documentation to further demonstrate DSN-related monitoring and oversight mechanisms.

PSCS-Lane provided a thorough description of its geocoding software, a detailed qualitative and quantitative time and distance analysis, and a comparison of the geographic distribution of members to providers; however, the CCO described using both member-level and provider-level ZIP Codes as the data points to conduct its analysis, instead of incorporating the entire physical addresses of the member and the provider. PSCS-Lane's analysis demonstrated the CCO's compliance with the time, distance, and overall member access standards, but measuring with a member's ZIP Code or "central point" to the closest provider within the same ZIP Code or "central point" produces an inaccurate estimate of the routine travel time and distance.

PSCS-Lane delegated oral health services to three DCOs: Advantage Dental (AD), Capital Dental Care (CDC), and ODS Community Dental (ODS). The CCO also delegated NEMT services to a local broker, Lane Transit District, and a pharmacy benefit manager for prescription services. All of these delegated entities were required to submit either weekly or monthly reporting deliverables and provider data. PSCS-Lane described the mechanisms in place to incorporate the acquired data into its monthly DSN analysis performed with the Quest Analytics geocoding and mapping tool. All findings were compiled in the CCO's Medicaid Monthly Adequacy Report and presented during the monthly Access to Care Workgroup meeting. If a trend of noncompliance with any of the time/distance standards is observed, the Provider Network Contacting team works in conjunction with the Workgroup to rectify any gaps in service or access.

PSCS-Lane's multi-functional integrated medical management platform was used by both the utilization and CM teams. Functions of this platform included, but were not limited to, determination and notification of medical, BH, dental, and pharmacy prior authorization and inpatient requests; grievances and appeals; referrals to community stakeholders; referrals for PSCS case management programs; health assessments; individualized member care plans; interventions; and interactions. Additionally, the CCO had access to provider EHRs to retrieve member data specifically for UM and CM activities and measure clinical quality indicators, including screenings and preventive measures.

Table B-21 provides the complete PSCS-Lane DSN Provider Narrative Report evaluation results.

Table B-21—PSCS–Lane—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0.5	**Findings**: PSCS-Lane's narrative response discussed and demonstrated how its network ensures time and distance standards for member access to health care are met; however, the reported routine travel time and distance standards were based on member-level and provider-level ZIP Code data instead of geocoding the full addresses. **Recommendation for the Next Submission:** PSCS-Lane should incorporate the entire physical addresses of all members and providers to establish data points when calculating routine time, distance, and overall member access standards.
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**: PSCS-Lane's narrative response discussed and demonstrated how its network ensures time and distance standards for member access to specialists; however, the reported routine travel time and distance standards were based on member-level and provider-level ZIP Code data instead of geocoding the full addresses.

Category Elements		Score	Findings/Recommendations
			Recommendation for the Next Submission: PSCS-Lane should incorporate the entire physical addresses of all members and providers to establish data points when calculating routine time, distance, and overall member access standards.
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
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

Category Elements		Score	Findings/Recommendations
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	**11.0**	**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 surveys; and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CCO needs to describe how it uses the input from its community advisory council.	1	Met

Category Elements		Score	Findings/Recommendations
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
23.	CCO describes its process for identifying and assessing all members for special health care needs.	1	Met

Category Elements		Score	Findings/Recommendations
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**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of PSCS-Lane's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Lane County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards, except for member access to PCPCH providers and PCPs.

All of the ZIP Codes within PSCS-Lane's service area are classified as rural except for the area surrounding Eugene and Springfield, Oregon. As shown below in Figure B-13 and Figure B-14, the graphic representations illustrate members without access to PCPCH practitioners and facilities within 30 and 60 miles/minutes. HSAG's analysis identified no PCPCH practitioners and facilities. All 56,984 (100 percent) members residing in urban areas were without access within 30 miles/minutes in the CCO's service area. Likewise, 10,317 (100 percent) members were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of PSCS-Lane's service area.

Figure B-13—PSCS-Lane—Urban Members Without Access to PCPCH Practitioners and Facilities

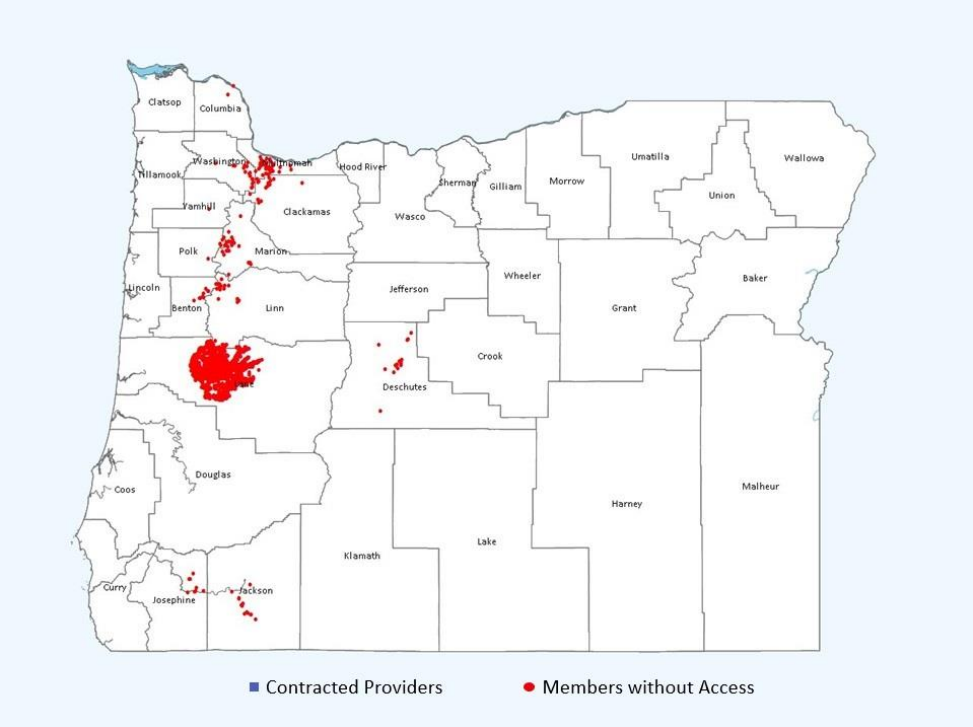
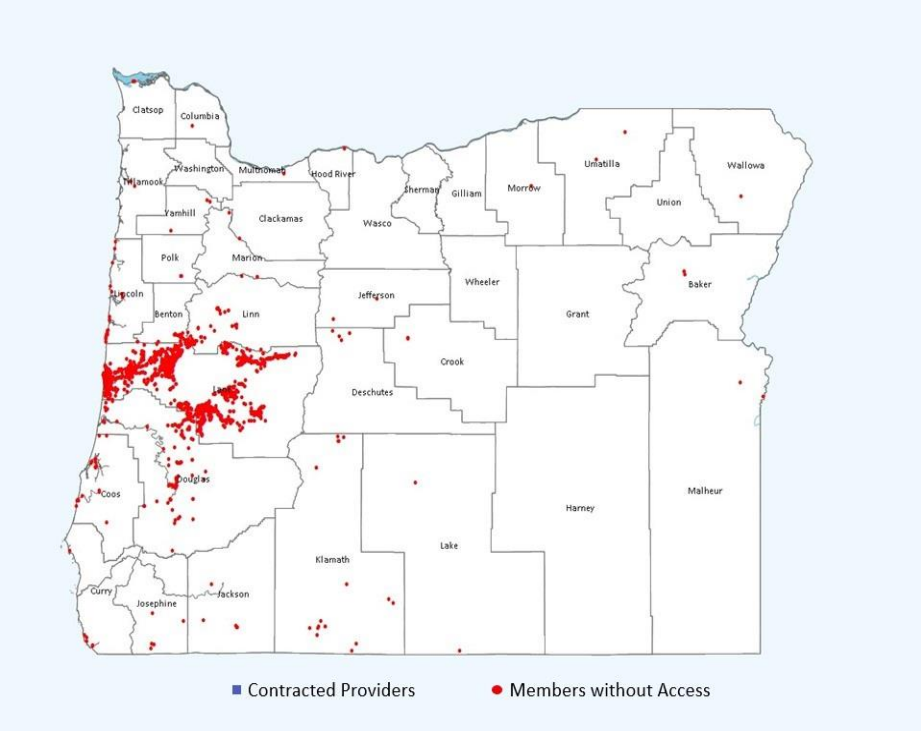


Figure B-14—PSCS-Lane—Rural Members Without Access to PCPCH Practitioners and Facilities



As shown below in Figure B-15 and Figure B-16, the graphic representations illustrate members without access to adult PCP practitioners within 30 and 60 miles/minutes. HSAG's analysis identified an aggregated count of 609 adult PCP practitioners at 93 locations. Of the 33,521 PSCS-Lane adult members residing in urban areas, 33,390 (99.6 percent) were without access within 30 miles/minutes in the CCO's service area. Likewise, 5,099 (79.8 percent) out of 6,388 adult CCO members residing in rural areas were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of PSCS-Lane's service area.

Figure B-15—PSCS-Lane—Urban Members Without Access to Adult PCP Practitioners

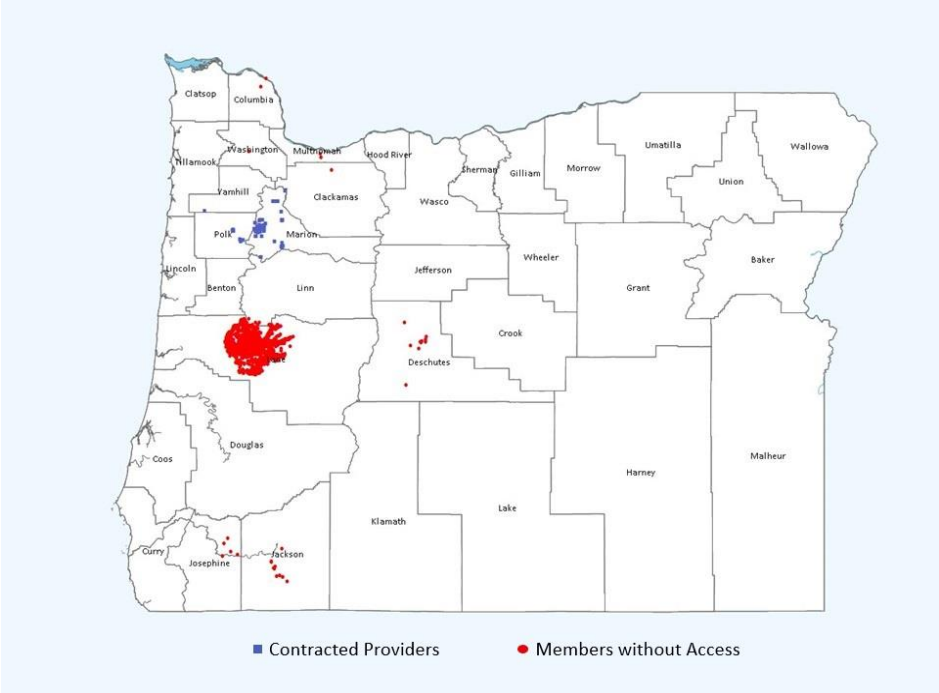
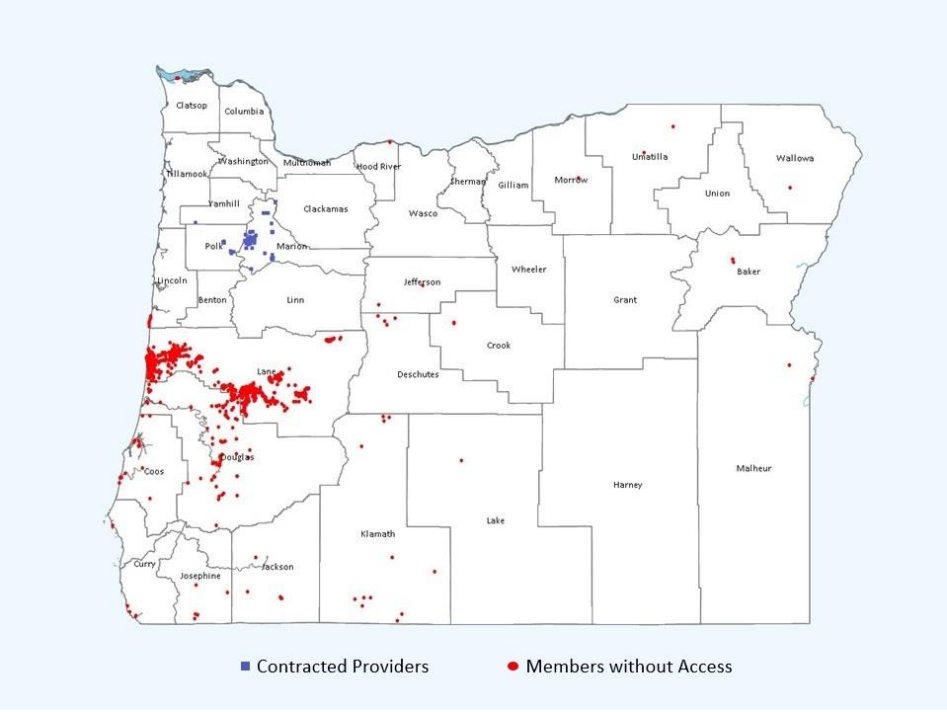


Figure B-16—PSCS-Lane—Rural Members Without Access to Adult PCP Practitioners



As shown below in Figure B-17 and Figure B-18, the graphic representations illustrate members without access to pediatric PCP practitioners within 30 and 60 miles/minutes. HSAG's analysis identified an aggregated count of 560 pediatric PCP practitioners at 90 locations. Of the 23,463 PSCS-Lane pediatric members residing in urban areas, 23,411 (99.8 percent) were without access within 30 miles/minutes in the CCO's service area. Likewise, 3,051 (77.7 percent) out of 3,929 pediatric CCO members residing in rural areas were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of PSCS-Lane's service area.

Figure B-17—PSCS-Lane—Urban Members Without Access to Pediatric PCP Practitioners

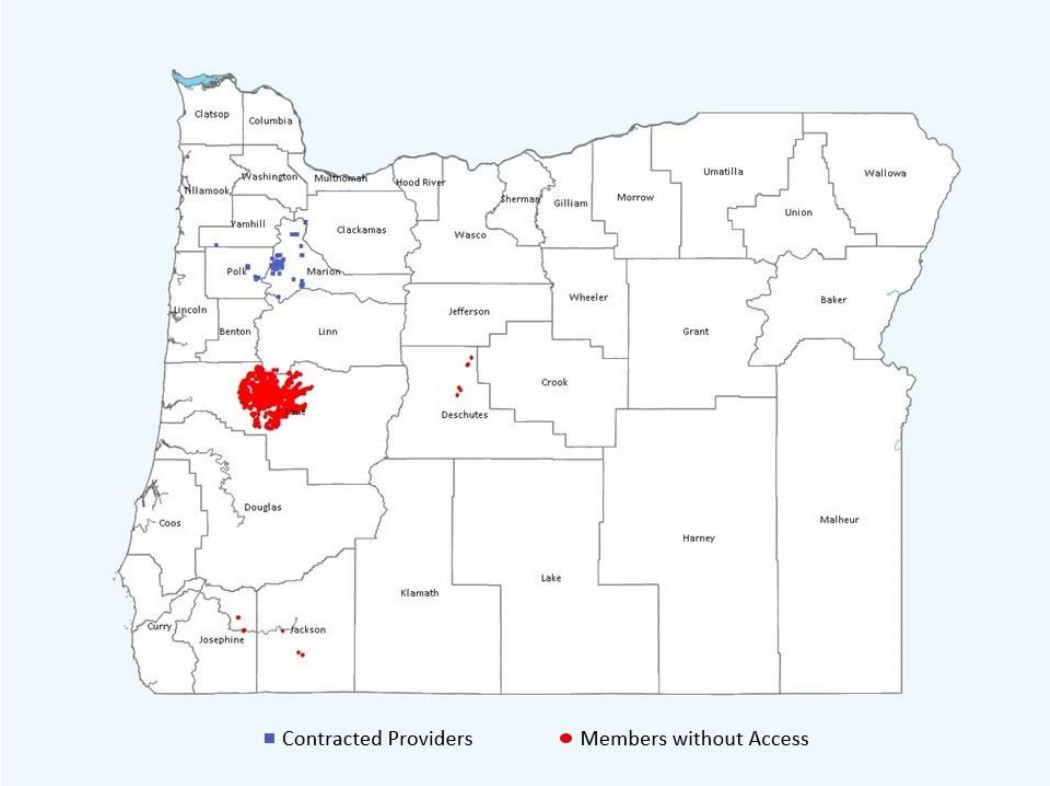
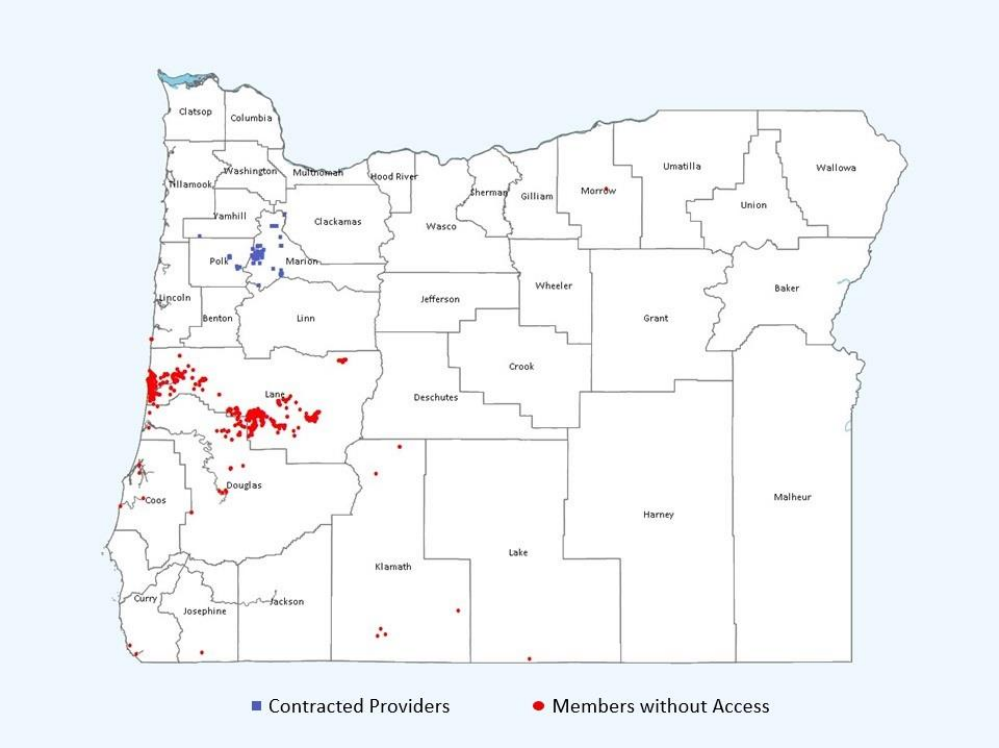


Figure B-18—PSCS-Lane—Rural Members Without Access to Pediatric PCP Practitioners



Provider Network Quality and Count Results

PSCS-Lane submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was excellent with no notable data quality issues.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 17,483 individual practitioner and 1,427 facility/business/service provider data records of contracted providers. Table B-22 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of PSCS-Lane's DSN Provider Capacity Report submission:

- Of the 17,483 total counted individual practitioners, 2,704 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 2,246 in Marion County and 458 in Polk County, neither of which border counties is the CCO's service area. PSCS-Lane populated no data records in Lane County.
- Of the 1,427 total counted facility/business/service providers, 159 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 136 in Marion County and 23 in Polk County, neither of which border counties in the CCO's service area. PSCS-Lane populated no data records in Lane County.
- No Health Education, Health Promotion, Health Literacy or Palliative Care individual practitioner data records were populated.

- No Non-Emergent Medical Transportation facility/business/service provider data records were populated.
- No School-based Health Centers and Urgent Care Center facility/business/service provider data records were populated.
- One Certified or Qualified Health Care Interpreters data record was populated; however, none were identified as contracted and in-network providers.
- Twenty Federally Qualified Health Centers data records were populated; however, none were identified as contracted and in-network providers.
- Two Indian Health Service and Tribal Health Services data records were populated; however, neither was identified as a contracted and in-network provider.
- Of the 395 total counted SUD Provider data records, 89 were identified as contracted and in-network providers. Of those SUD Provider data records, none were identified as speaking a non-English language.
- Of the 16 total counted Traditional Health Workers data records, four were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining 12 contracted and out-of-network Traditional Health Workers data records, none were identified as speaking a non-English language.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-22—Individual Practitioner and Facility/Business/Service Provider Counts for PSCS-Lane

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	461	2.6%	443	16.4%	0	0.0%
Specialty Provider	12,445	71.2%	1,279	47.3%	11,166	75.6%
Oral Health Provider	829	4.7%	237	8.8%	592	4.0%
MH Provider	3,336	19.1%	652	24.1%	2,684	18.2%
SUD Provider	395	2.3%	89	3.3%	306	2.1%
Certified or Qualified Health Care Interpreters	1	<0.1%	0	0.0%	1	<0.1%
Traditional Health Workers	16	0.1%	4	0.1%	12	0.1%
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**17,483**	**100.0%**	**2,704**	**100.0%**	**14,761**	**100.0%**
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	36	2.5%	1	0.6%	35	2.8%
Ambulance and Emergency Medical Transportation	108	7.6%	11	6.9%	97	7.6%

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Federally Qualified Health Centers	20	1.4%	0	0.0%	20	1.6%
Home Health	32	2.2%	7	4.4%	25	2.0%
Hospice	25	1.8%	5	3.1%	20	1.6%
Hospital	73	5.1%	10	6.3%	63	5.0%
Imaging	31	2.2%	2	1.3%	29	2.3%
Indian Health Service and Tribal Health Services	2	0.1%	0	0.0%	2	0.2%
MH Crisis Services	72	5.0%	15	9.4%	57	4.5%
Community Prevention Services	39	2.7%	6	3.8%	33	2.6%
Non-Emergent Medical Transportation	0	0.0%	0	0.0%	0	0.0%
Pharmacies	659	46.2%	60	37.7%	599	47.2%
Durable Medical Providers	238	16.7%	28	17.6%	210	16.6%
Post-hospital Skilled Nursing Facility	77	5.4%	10	6.3%	67	5.3%
Rural Health Centers	15	1.1%	4	2.5%	11	0.9%
School-based Health Centers	0	0.0%	0	0.0%	0	0.0%
Urgent Care Center	0	0.0%	0	0.0%	0	0.0%
Overall	**1,427**	**100.0%**	**159**	**100.0%**	**1,268**	**100.0%**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

PacificSource Community Solutions–Marion Polk

DSN Provider Narrative Evaluation Results

PacificSource Community Solutions–Marion Polk (PSCS-MP) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Marion and Polk counties.

The CCO submitted a DSN Provider Narrative Report with comprehensive and detailed responses, accompanied with policies, desktop procedures, data dashboards, analytics, and other supporting documentation to further demonstrate DSN-related monitoring and oversight mechanisms.

PSCS-MP provided a thorough description of its geocoding software, a detailed qualitative and quantitative time and distance analysis, and a comparison of the geographic distribution of members to providers; however, the CCO described using both member-level and provider-level ZIP Codes as the data points to conduct its analysis, instead of incorporating the entire physical addresses of the member and the provider. PSCS-MP's analysis demonstrated the CCO's compliance with the time, distance, and overall member access standards, but measuring with a member's ZIP Code or "central point" to the closest provider within the same ZIP Code or "central point" produces an inaccurate estimate of the routine travel time and distance.

PSCS-MP described using the approach of regional care teams (RCTs), which consist of UM and CM interdisciplinary teams with clinical expertise in BH and population health. Individual assessments were administered to members to determine the most befitting RCT CM program for individual physical and BH; TOCs; and/or social health determinants care coordination, treatment, and/or care planning. PSCS-MP's regional designation assured that team members had concentrated knowledge based on the MH and SUD services, resources, and community agencies available in that area.

PSCS-MP's narrative response addressed the availability of SUD treatment for adults and children. A few mechanisms described by the CCO to monitor member access were grievance and appeals trends related to dissatisfaction with wait times, delays in appointment scheduling, occurrence of rescheduled appointments, issues with transportation, and poor service experience. Additionally, PSCS-MP conducted annual site reviews of CMHPs and providers with a Certificate of Approval from the Health Systems Division of OHA. The CCO's site review included a sample review of charts to ensure interrater reliability, consistency, and encounter data validation. Providers identified as noncompliant with the OAR and CCO contract provisions were issued a CAP, which addressed the findings and documented the expectation that any areas of deficiency will be resolved and how effectiveness will be measured.

Table B-23 provides the complete PSCS-MP DSN Provider Narrative Report evaluation results.

Table B-23—PSCS-MP—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0.5	**Findings**: PSCS-MP's narrative response discussed and demonstrated how its network ensures time and distance standards for member access to health care are met; however, the reported routine travel time and distance standards were based on member-level and provider-level ZIP Code data instead of geocoding the full addresses. **Recommendation for the Next Submission:** PSCS-MP should incorporate the entire physical addresses of all members and providers to establish data points when calculating routine time, distance, and overall member access standards.
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**: PSCS-MP's narrative response discussed and demonstrated how its network ensures time and distance standards for member access to specialists; however, the reported routine travel time and distance standards were based on member-level and provider-level ZIP Code data instead of geocoding the full addresses.

	Category Elements	Score	Findings/Recommendations
			Recommendation for the Next Submission: PSCS-MP should incorporate the entire physical addresses of all members and providers to establish data points when calculating routine time, distance, and overall member access standards.
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
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

Category Elements		Score	Findings/Recommendations
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	**11.0**	**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 surveys; and Consumer Assessment of Healthcare Providers and Systems (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

Category Elements		Score	Findings/Recommendations
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
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**

Category Elements		Score	Findings/Recommendations
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**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of PSCS-MP's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Marion County and Polk County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards, except for member access to PCPCH providers and PCP practitioners.

The ZIP Codes within PSCS-MP's service area are mixed with many of the counties classified as rural except for the area around Albany, Salem, and Dallas, Oregon. As shown below in Figure B-19 and Figure B-20, the graphic representations illustrate members without access to PCPCH providers within 30 and 60 miles/minutes. HSAG's analysis identified no PCPCH providers. All 101,783 (100 percent) members residing in urban areas were without access within 30 miles/minutes in the CCO's service area. Likewise, 12,097 (100 percent) members residing in rural areas were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of PSCS-MP's service area.

Figure B-19—PSCS-MP—Urban Members Without Access to PCPCH Practitioners and Facilities

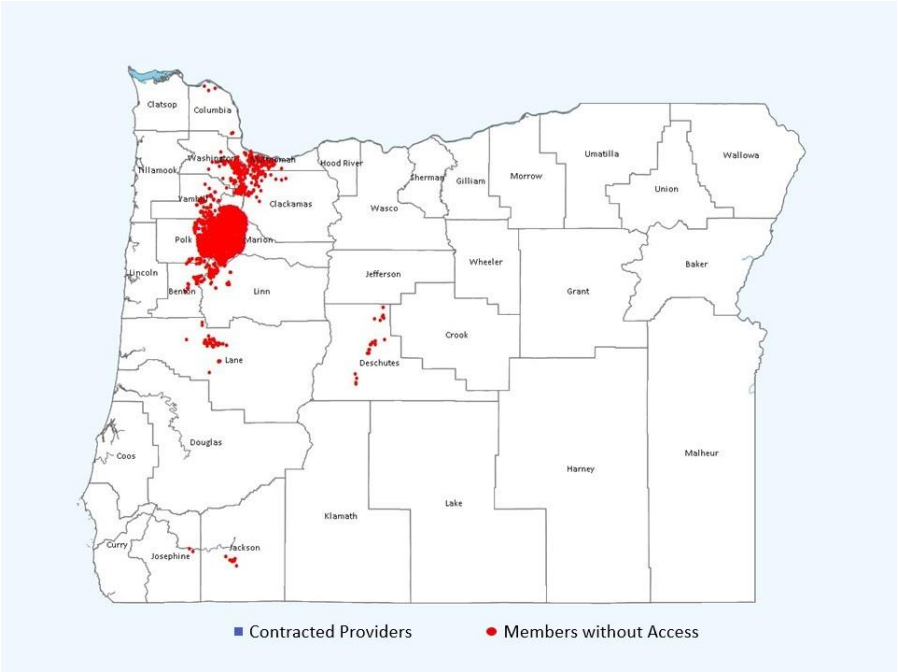
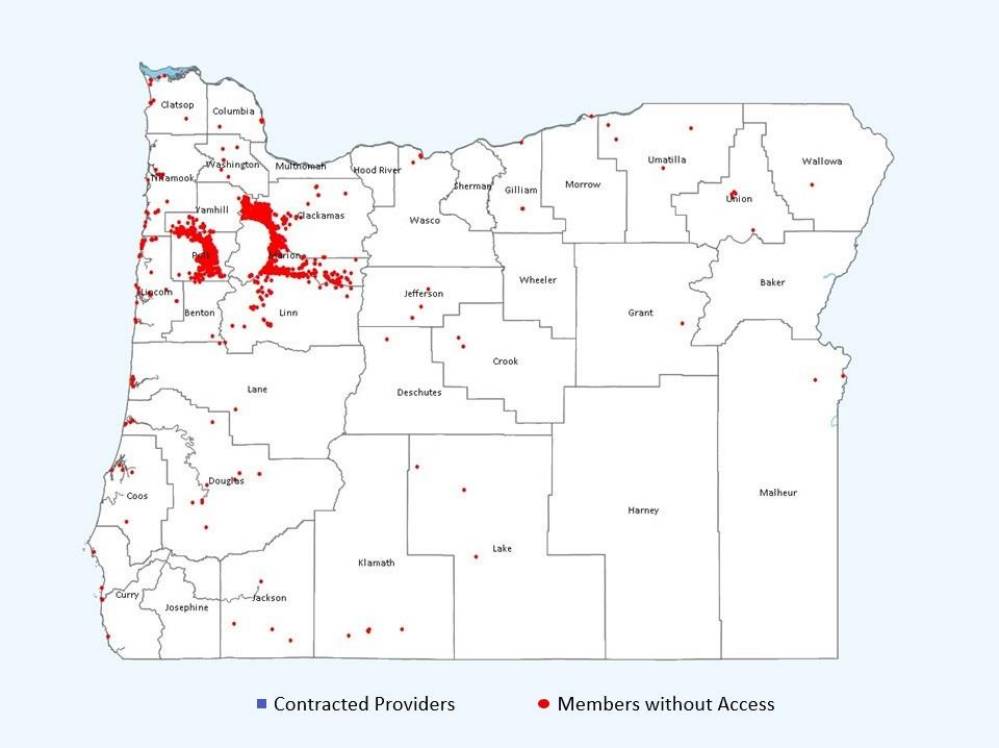


Figure B-20—PSCS-MP—Rural Members Without Access to PCPCH Practitioners and Facilities



As shown below in Figure B-21 and Figure B-22, the graphic representations illustrate members without access to adult PCP practitioners within 30 and 60 miles/minutes. HSAG's analysis identified an aggregated count of 674 adult PCP practitioners at 94 locations. Of the 51,693 PSCS-MP adult members residing in urban areas, 51,608 (99.8 percent) were without access within 30 miles/minutes in the CCO's service area. Likewise, 2,304 (34.4 percent) out of 6,688 adult CCO members residing in rural areas were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of PSCS-MP's service area.

Figure B-21—PSCS-MP—Urban Members Without Access to Adult PCP Practitioners

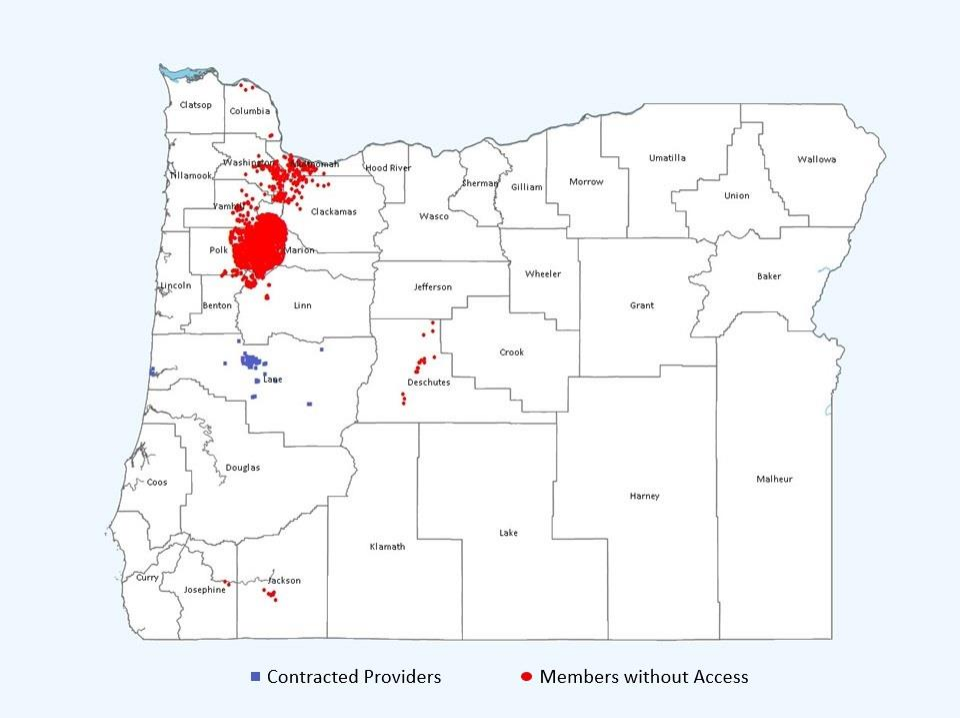
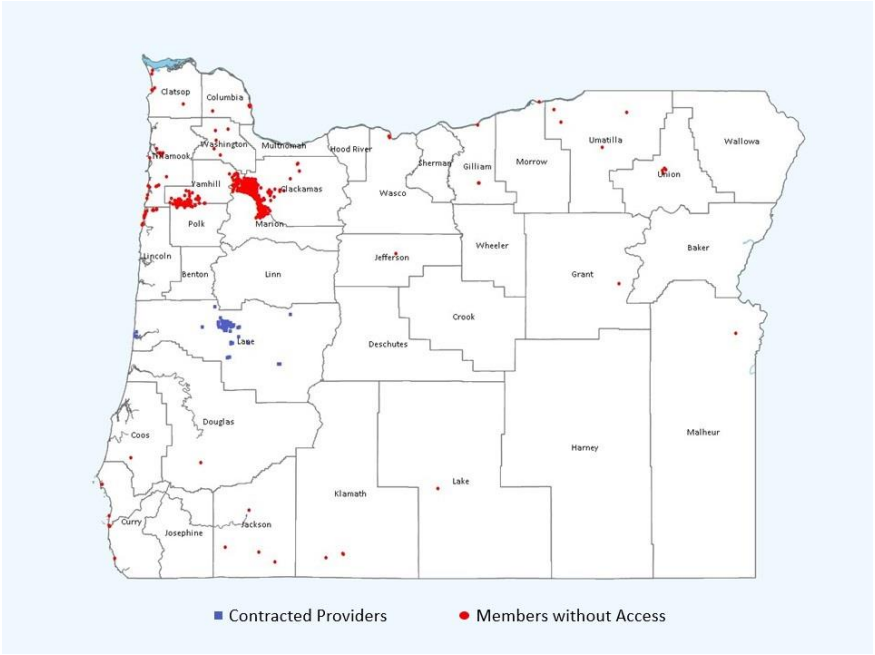


Figure B-22—PSCS-MP—Rural Members Without Access to Adult PCP Practitioners



As shown below in Figure B-23 and Figure B-24, the graphic representations illustrate members without access to pediatric PCP practitioners within 30 and 60 miles/minutes. HSAG's analysis identified an aggregated count of 719 pediatric PCP practitioners at 95 locations. Of the 51,693 PSCS-MP adult members, 51,608 (99.8 percent) residing in urban areas were without access within 30 miles/minutes in the CCO's service area. Likewise, 2,304(34.4 percent) out of 6,688adult CCO members residing in rural areas were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of PSCS-MP's service area.

Figure B-23—PSCS-MP—Urban Members Without Access to Pediatric PCP Practitioners

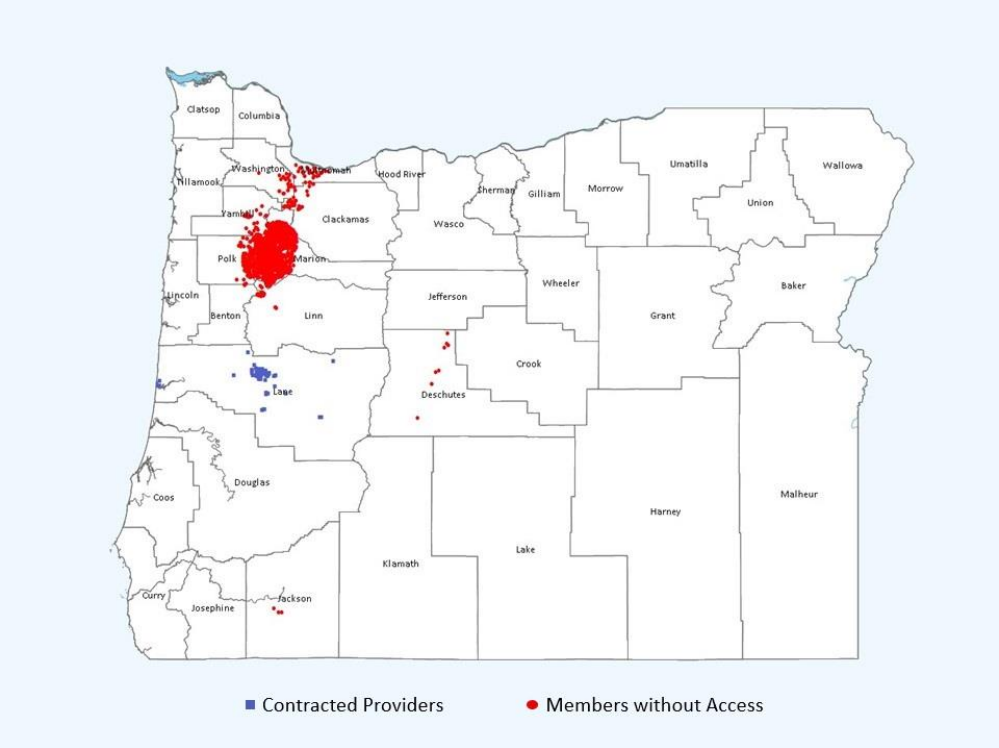
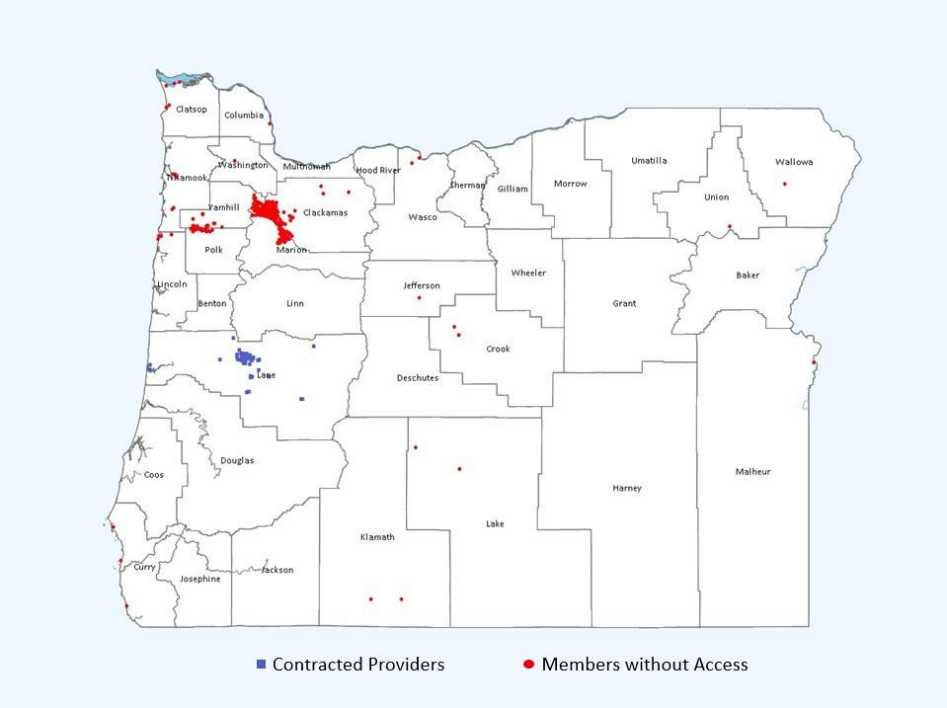


Figure B-24—PSCS-MP—Rural Members Without Access to Pediatric PCP Practitioners



Provider Network Quality and Count Results

PSCS-MP submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was excellent with no notable data quality issues.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 17,364 individual practitioner and 1,418 facility/business/service provider data records of contracted providers. Table B-24 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of PSCS-MP's DSN Provider Capacity Report submission:

- Of the 17,364 total counted individual practitioners, 2,878 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 2,878 in Lane County, which does not border the CCO's service area. PSCS-MP populated no data records in Marion County or Polk County.
- Of the 1,418 total counted facility/business/service providers, 172 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 172 in Lane County, which does not border the CCO's service area. PSCS-MP populated no data records in Marion County and Polk County.

- No Health Education, Health Promotion, Health Literacy or Palliative Care individual practitioner data records were populated.
- No School-based Health Centers and Urgent Care Center facility/business/service provider data records were populated.
- One Certified or Qualified Health Care Interpreters data record was populated; however, it was not identified as a contracted and in-network provider.
- Two Indian Health Service and Tribal Health Services data records were populated; however, neither was identified as a contracted and in-network provider.
- Fifteen Rural Health Centers data records were populated; however, none were identified as contracted and in-network providers.
- Of the 395 total counted SUD Provider data records, 151 were identified as contracted and in-network providers. Of those SUD Provider data records, two were also identified as speaking a non-English language.
- Of the 16 total counted Traditional Health Workers data records, seven were contracted and in-network providers; however, none were identified as speaking a non-English language. Of the remaining nine contracted and out-of-network Traditional Health Workers data records, none were identified as speaking a non-English language.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-24—Individual Practitioner and Facility/Business/Service Provider Counts for PSCS-MP

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	418	2.4%	418	14.5%	0	0.0%
Specialty Provider	12,373	71.3%	1,156	40.2%	11,217	77.4%
Oral Health Provider	829	4.8%	173	6.0%	656	4.5%
MH Provider	3,332	19.2%	973	33.8%	2,359	16.3%
SUD Provider	395	2.3%	151	5.2%	244	1.7%
Certified or Qualified Health Care Interpreters	1	<0.1%	0	0.0%	1	<0.1%
Traditional Health Workers	16	0.1%	7	0.2%	9	0.1%
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**17,364**	**100.0%**	**2,878**	**100.0%**	**14,486**	**100.0%**

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	36	2.5%	6	3.5%	30	2.4%
Ambulance and Emergency Medical Transportation	108	7.6%	9	5.2%	99	7.9%
Federally Qualified Health Centers	20	1.4%	1	0.6%	19	1.5%
Home Health	29	2.0%	3	1.7%	26	2.1%
Hospice	25	1.8%	2	1.2%	23	1.8%
Hospital	73	5.1%	18	10.5%	55	4.4%
Imaging	30	2.1%	6	3.5%	24	1.9%
Indian Health Service and Tribal Health Services	2	0.1%	0	0.0%	2	0.2%
MH Crisis Services	72	5.1%	8	4.7%	64	5.1%
Community Prevention Services	39	2.8%	1	0.6%	38	3.0%
Non-Emergent Medical Transportation	1	0.1%	1	0.6%	0	0.0%
Pharmacies	655	46.2%	70	40.7%	585	47.0%
Durable Medical Providers	236	16.6%	38	22.1%	198	15.9%
Post-hospital Skilled Nursing Facility	77	5.4%	9	5.2%	68	5.5%
Rural Health Centers	15	1.1%	0	0.0%	15	1.2%
School-based Health Centers	0	0.0%	0	0.0%	0	0.0%
Urgent Care Center	0	0.0%	0	0.0%	0	0.0%
Overall	**1,418**	**100.0%**	**172**	**100.0%**	**1,246**	**100.0%**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Trillium Community Health Plan, Inc.

DSN Provider Narrative Evaluation Results

Trillium Community Health Plan, Inc. (TCHP) contracts with OHA to provide physical, behavioral, and dental health services to members residing in Clackamas, Lane, Multnomah, and Washington counties, as well as parts of Douglas and Linn counties.

Since OHA's approval of TCHP's request for contract expansion into the Tri-County (Clackamas, Multnomah, and Washington) was effective September 1, 2020, the CCO's narrative response only addressed elements as they pertain to members residing in Lane County and parts of Douglas and Linn counties.

The CCO submitted a DSN Provider Narrative Report with detailed responses, accompanied with geo-mapping, analytics, and other supporting documentation to further demonstrate DSN-related monitoring and oversight mechanisms.

TCHP used Quest Analytics geocoding software to perform quarterly analysis to monitor the network and conduct time and distance calculations. In instances in which there was a change to the DSN, such as termination of a provider group, TCHP would conduct an ad-hoc analysis to ensure that the material change did not result in members experiencing a gap in any covered services. TCHP explained that two of its three DCOs utilized geocoding software to monitor time and distance standards and the remaining DCO did not use any geocoding application. That DCO relied on assigning members to the closest primary care dentist within the member's ZIP Code to assure time and distance. As a mechanism of delegate oversight and monitoring of the geographic distribution of members, TCHP used its own geocoding software to conduct aggregated mapping and time and distance standards to ensure member access and DCO compliance.

TCHP described the integrated health management tool used to house a single comprehensive member record that supports both care coordination and UM activities and functions. The tool delivered a team-based approach to care with a member-centric view to review assessments, referrals and prior authorizations, service utilization, member contacts, and program participation. In conjunction with the functions listed above, the tool also assessed and addressed the current and future needs of each member. Another form of innovative technology used by TCHP was its hosted Trillium Resource Exchange (T-Rex). The search engine was available to members on the CCO's website and steered members to free or reduced cost services such as medical care, food, job training, and more in TCHP's service area.

Annually, TCHP completed an analysis report specific to the availability of practitioners within its network. In addition to describing and demonstrating member access to PCP and specialty care, the report also incorporated a detailed analysis of member characteristics and demographics such as race, ethnicity, gender, age, and non-English language spoken. TCHP did not specifically gather the religious and cultural preferences of its membership; however, the CCOs monitored the religious representation

of those citizens that reside in the service area via the U.S. Religion Census: Congregation and Membership Study. Additionally, TCHP was an active participant of the Live Healthy Lane, Community Health Coalition. The coalition conducted informant interviews, surveys, and focus groups to identify community themes, strengths, and the preferences of Lane County residents. The coalition engaged diverse demographic groups, such as those living in rural communities, LGBTQIA+, seniors, people living with disabilities, and youth, to ensure that information gathered represented the diverse population of people in Lane County. TCHP applied knowledge gained to ensure that the network included culturally and linguistically appropriate services.

Table B-25 provides the complete TCHP DSN Provider Narrative Report evaluation results.

Table B-25—TCHP—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0.5	**Findings**: TCHP's narrative response and supplemental documentation described the geographic distribution of members compared to providers; however, the CCO did not address member access to MH/BH and SUD as separate entities, both categories of service were combined. **Recommendation for the Next Submission:** TCHP should describe MH/BH and SUD as separate categories of service when comparing the geographic distribution of these providers compared with the geographic distribution of members.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0.5	**Findings**: TCHP's narrative response and supplemental documentation described time and distance standards; however, the CCO did not address member access to MH/BH and SUD as separate entities, both categories of service were combined. **Recommendation for the Next Submission:** TCHP should describe MH/BH and SUD as separate categories of service when addressing how the network ensures that the time and distance standards for member access are 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	1	Met

	Category Elements	Score	Findings/Recommendations
	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.	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
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

Category Elements		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	**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.	0.5	**Findings**: TCHP's narrative response addressed the different reports and systems used to monitor the prevalence of diseases that require access to a specialist throughout its membership; however, the CCO did not submit any analysis to demonstrate the prevalence of diseases. **Recommendation for the Next Submission:** TCHP should submit analysis to demonstrate 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 surveys; and Consumer Assessment of Healthcare	0.5	**Findings**: TCHP's narrative response described how it incorporated complaints, grievances, CAHPS, and MHSIP/YSS-F/YSS survey results into network adequacy decisions; however, the CCO did not address how it incorporated input from its CAC into its network adequacy

	Category Elements	Score	Findings/Recommendations
	Providers and Systems (CAHPS®). The CCO needs to describe how it uses the input from its community advisory council.		decisions. Additionally, the CCO did not incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate the network adequacy decisions. **Recommendation for the Next Submission:** TCHP should describe how it incorporates input from its CAC into its network adequacy decisions and include examples, applicable scenarios, and/or supporting documentation to demonstrate the 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**
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

Category Elements		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.	0.5	**Findings**: TCHP's narrative response addressed how interdisciplinary teams are used to coordinate services and manage its ED Diversion program; however, the CCO did not address how it determines if care coordinated by interdisciplinary care teams is adequate to reduce hospital readmission and emergency room visits, and whether these efforts are adequate. **Recommendation for the Next Submission:** TCHP should describe how it determines if care coordinated by interdisciplinary care teams is adequate to reduce hospital readmission and emergency room visits, and whether these efforts are adequate.
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	**4.5**	**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.	0.5	**Findings**: TCHP's narrative response addressed different processes and/or procedures the CCO used to monitor and analyze under- and overutilization; however, the CCO did not incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate actions taken by the CCO to address underutilization and overutilization. **Recommendation for the Next Submission:**

Category Elements		Score	Findings/Recommendations
			TCHP should incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate actions taken by the CCO to address underutilization and overutilization.
Total Score			**Out of Possible 2.0**

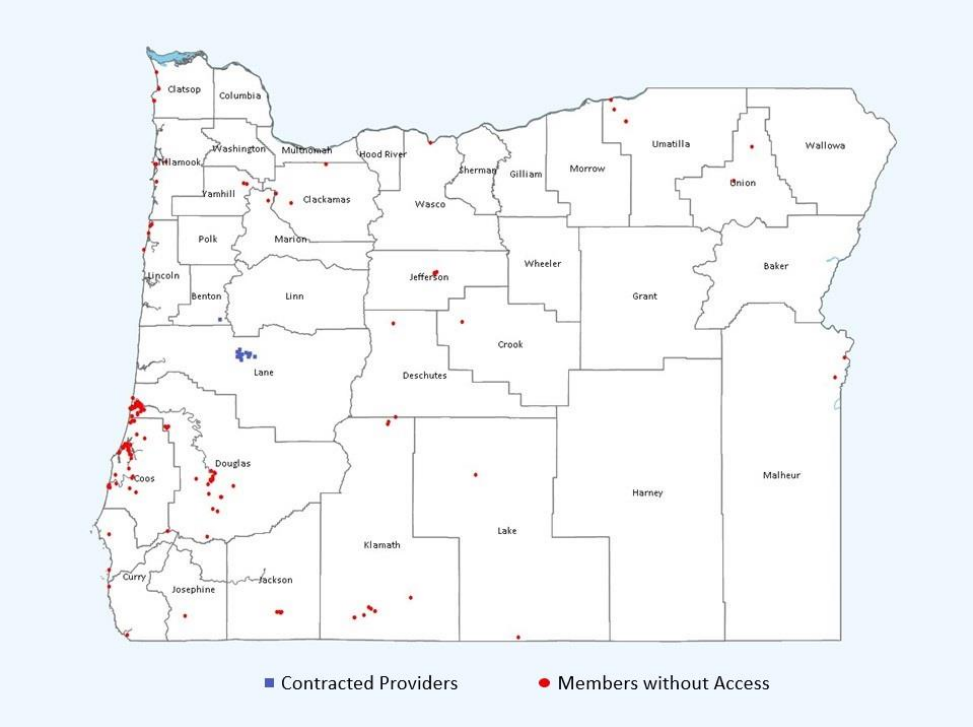
DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of TCHP's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Lane County and parts of Douglas County and Linn County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards, except for member access to PCPCH providers.

The ZIP Codes within TCHP's service areas represent a mix of urban and rural areas. As shown below in Figure B-25, the graphic representation illustrates members residing in rural areas without access to PCPCH practitioners and facilities within TCHP's service area. HSAG's analysis identified an aggregated count of 21 PCPCH practitioners and facilities at 21 locations. Of the 8,100 TCHP members, 1,408 (17.4 percent) were without access within 60 miles/minutes in the CCO's service area.

Figure B-25—TCHP—Rural Members Without Access to PCPCH Practitioners and Facilities



Provider Network Quality and Count Results

TCHP submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was excellent with a few data quality issues. The following area of concern was observed in TCHP's report:

- Of the records submitted, only 91.6 percent had values populated in the Credentialing Date data field.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 3,056 individual practitioner and 834 facility/business/service provider data records of contracted providers. Table B-26 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of TCHP's DSN Provider Capacity Report submission:

- Of the 3,056 total counted individual practitioners, 2,297 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 57 in Douglas County, 2,237 in Lane County, and the remaining three in the bordering county of Linn.
- Of the 834 total counted facility/business/service providers, 150 data records were identified as contracted and in-network providers. The geographic distribution of the data records was five in Douglas County, 144 in Lane County, and the remaining one in the bordering county of Linn.
- No Certified or Qualified Health Care Interpreters or Health Education, Health Promotion, Health Literacy individual practitioner data records were populated.
- No Imaging or Indian Health Service and Tribal Health Services facility/business/service provider data records were populated.
- Of the 308 total counted SUD Provider data records, 152 were identified as contracted and in-network providers. Of those SUD Provider data records, one was also identified as speaking a non-English language.
- The one Palliative Care data record was identified as a contracted and in-network provider; however, the provider was not identified as speaking a non-English language.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-26—Individual Practitioner and Facility/Business/Service Provider Counts for TCHP

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	360	11.8%	259	11.3%	101	13.3%
Specialty Provider	690	22.6%	563	24.5%	127	16.7%
Oral Health Provider	253	8.3%	185	8.1%	68	9.0%
MH Provider	1,363	44.6%	1,100	47.9%	263	34.7%
SUD Provider	308	10.1%	152	6.6%	156	20.6%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%	0	0.0%
Traditional Health Workers	81	2.7%	37	1.6%	44	5.8%

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	1	<0.1%	1	<0.1%	0	0.0%
Overall	**3,056**	**100.0%**	**2,297**	**100.0%**	**759**	**100.0%**
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	1	0.1%	1	0.7%	0	0.0%
Ambulance and Emergency Medical Transportation	1	0.1%	1	0.7%	0	0.0%
Federally Qualified Health Centers	10	1.2%	2	1.3%	8	1.2%
Home Health	10	1.2%	5	3.3%	5	0.7%
Hospice	6	0.7%	4	2.7%	2	0.3%
Hospital	8	1.0%	8	5.3%	0	0.0%
Imaging	0	0.0%	0	0.0%	0	0.0%
Indian Health Service and Tribal Health Services	0	0.0%	0	0.0%	0	0.0%
MH Crisis Services	6	0.7%	5	3.3%	1	0.1%
Community Prevention Services	13	1.6%	5	3.3%	8	1.2%
Non-Emergent Medical Transportation	1	0.1%	1	0.7%	0	0.0%
Pharmacies	650	77.9%	73	48.7%	577	84.4%
Durable Medical Providers	91	10.9%	26	17.3%	65	9.5%
Post-hospital Skilled Nursing Facility	29	3.5%	13	8.7%	16	2.3%
Rural Health Centers	2	0.2%	2	1.3%	0	0.0%
School-based Health Centers	2	0.2%	2	1.3%	0	0.0%
Urgent Care Center	4	0.5%	2	1.3%	2	0.3%
Overall	**834**	**100.0%**	**150**	**100.0%**	**684**	**100.0%**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Umpqua Health Alliance, LLC

DSN Provider Narrative Evaluation Results

Umpqua Health Alliance, LLC (UHA) contracts with OHA to provide physical, behavioral, and dental health services to members residing in all Douglas County ZIP Codes, except 97441, 97467, and 97473.

The CCO submitted a DSN Provider Narrative Report with limited responses that lacked detail. UHA's submission was accompanied with policies, a provider handbook, data monitoring dashboards, and a provider orientation training slide deck; however, the narrative response did not specifically reference which supporting documents apply to which elements. In one narrative response, the CCO referenced a document included in the "DSN UHA Narratives" tab of the Excel spreadsheet, but this tab was completely blank.

UHA described that a care coordinator is assigned to each member throughout a TOC. For example, upon receiving notification of a member's inpatient admission, a care coordinator was assigned to work with both the member and facility in an effort to maintain continuity of care and facilitate successful transitions. To establish a connection and rapport, the CCO's care coordinators conducted face-to-face meetings to complete an assessment of the member's needs and created an individualized care plan. During an inpatient hospitalization, the care coordinator completed weekly utilization reviews and updated the care plan accordingly. This information was input into the CCO's EHR TOC tool, which guided all discharge planning decision making. Prior to discharge, the member was assigned a UHA case manager to provide support preparing the member to return home or for placement in a long-term facility; the case manager also continued to provide coordination of care after discharge.

UHA described utilizing Collective Medical, a web-based program to track member ED visits and hospital admissions. The CCO encouraged utilization of this platform by procuring subscriptions for contracted providers. The platform issued early notification of members receiving care in the ED, which resulted in UHA's case management coordinators and contracted providers proactive approach to assisting members with timely follow-up appointments and referrals. Additionally, the web-based program's notification of inpatient admissions was leveraged to identify appropriate discharge needs or placements, resulting in the reduction of readmissions.

Table B-27 provides the complete UHA DSN Provider Narrative Report evaluation results.

Table B-27—UHA—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0	**Findings**: UHA's narrative response included a broad description of its geographic service area. The CCO referenced an attached chart in the "DSN UHA Narratives" tab; however, this tab was bare, and it was unclear if any of the supporting documents were included the "chart." The CCO also did not describe its process and/or procedure for conducting an analysis of the geographic distribution of all providers (i.e., PCPs; specialists; and MH/BH, SUD, and oral health providers) compared to the geographic distribution of members. Additionally, UHA's narrative response did not address how the CCO conducts vendor/delegate oversight and monitoring of the geographic distribution of members compared to providers in its narrative. **Recommendation for the Next Submission:** UHA should describe the geographic distribution of all providers (i.e., PCPs; specialists; and MH/BH, SUD, and oral health providers) compared to the geographic distribution of members. The CCO should include analysis of how members can access services, with supporting documentation. Additionally, the CCO should describe how it conducts vendor/delegate oversight and monitoring of the geographic distribution of members.
2.	CCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0	**Findings**: UHA's narrative response stated that Quest Analytics is used to geomap time and distance standards; however, the CCO did not include its methodology or mechanisms demonstrating how the network ensures that the time and distance standards for member access to health care are met. Additionally, UHA's narrative response only included

Category Elements		Score	Findings/Recommendations
			percentages of members with access to care instead of also including time and distance analysis to demonstrate member access to care across all three standards—time, distance, and percentage. UHA also did not address how the CCO conducts vendor/delegate oversight and monitoring of the time and distance standards for member access to health care. **Recommendation for the Next Submission:** UHA should discuss how the network ensures that the time and distance standards for member access to health care are met. The CCO should also describe the methodology used to demonstrate compliance with the three standards—time, distance, and percentage. Additionally, the CCO should submit analysis to demonstrate member access within all of the standards.
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.	0.5	**Findings**: UHA's narrative response described that quarterly "Access to Care" surveys are distributed to each provider and specialty group to ensure the provisions of appropriate urgent, emergent, crisis, and triage services are available 24/7 for UHA members; however, the CCO did not describe how the monitoring activities are analyzed to ensure compliance. Additionally, the CCO did not describe or address how it conducts vendor/delegate oversight and monitoring of appropriate urgent, emergency, crisis, and triage services 24 hours a day/7 days a week for all members. **Recommendation for the Next Submission:** UHA should describe how the monitoring activities are analyzed to ensure compliance and how it conducts vendor/delegate oversight and monitoring of appropriate urgent,

Category Elements		Score	Findings/Recommendations
			emergency, crisis, and triage services 24 hours a day/7 days a week for all members.
4.	CCO analyzes wait times for appointments with providers, including specialists.	0.5	**Findings**: UHA's narrative response did not describe how the CCO conducted vendor/delegate oversight and monitoring of appointment wait times. Additionally, the CCO did not describe how subcontractor activities are analyzed to ensure compliance. **Recommendation for the Next Submission:** UHA should address how vendor/delegate oversight and monitoring of wait times for appointments are conducted and analyzed the CCO conducted vendor/delegate oversight and monitoring of appointment wait times.
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**: UHA's narrative response referenced ratios for PCPs, specialists, and MH and SUD providers servicing both adults and pediatric members. The CCO also included a ratio specific to members and geriatric providers; however, the CCO did not address the ratios for oral health and availability of acute care beds. Additionally, the CCO did not explain its process or methodology for calculating the submitted member-to-provider ratios and how the calculations are analyzed to determine whether or not member access to health care is in compliance. **Recommendation for the Next Submission:** UHA should describe the ratios for oral health and availability of acute care beds, and explain its process or methodology for calculating the submitted member-to-provider ratios and how

Category Elements		Score	Findings/Recommendations
			the calculations are analyzed to determine whether or not member access to health care is in compliance.
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**: UHA's narrative response described its members having access to MH disorders for crisis, outpatient and intensive outpatient care services such as ACT, residential, and inpatient services for adults and children; however, the CCO did not address the availability of DBT and ICTS. Additionally, UHA did not address whether it considers the available services to be adequate to meet the needs of its membership. **Recommendation for the Next Submission:** UHA should describe the availability of DBT and ICTS. The CCO should also describe whether it considers the available services to be adequate to meet the needs of its membership.
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

Category Elements		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**: UHA's narrative response described its use of alternative therapies and how members can access chiropractic, acupuncture, and physical therapy with massage services for pain management treatment; however, the CCO did not address how it determines if the availability of services is adequate and if UHA considers the available therapies adequate to meet the needs of its membership. **Recommendation for the Next Submission:** UHA should describe how it determines if the availability of alternative therapies is adequate, and if UHA considers the available therapies adequate to meet the needs of its membership.
	Total Score	**7.5**	**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.	0.5	**Findings**: UHA's narrative response described its process for making provider assignments and addressed its data sources where information related to the cultural, language, disability, and special health care needs of its membership is gathered; however, the CCO did not describe its process and/or procedure for conducting analysis of the data. Additionally, UHA did not submit analysis to demonstrate the characteristics and needs of its membership. **Recommendation for the Next Submission:** UHA should describe its process and/or procedure for conducting analysis of the data and submit analysis to demonstrate the characteristics and needs of its membership.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	0.5	**Findings**: UHA's narrative response addressed its data sources where information related to the prevalence of diseases across

Category Elements		Score	Findings/Recommendations
			its membership is gathered; however, the CCO did not submit analysis of its membership to demonstrate the prevalence of diseases that require access to specialists. **Recommendation for the Next Submission:** UHA should describe the prevalence of diseases that require access to specialists among the member population. Additionally, the CCO should submit an analysis of its membership demonstrating 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	**2.0**	**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 surveys; and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CCO needs to describe how it uses the input from its community advisory council.	0.5	**Findings**: UHA's narrative response described how it incorporates complaint and grievance analysis and input from its CAC into network adequacy decisions; however, its response did not address if adult (MHSIP), family (YSS-F), and child (YSS) MH surveys and CAHPS surveys are used to gather member feedback and, if so, how it influences decisions related to its DSN. **Recommendation for the Next Submission:** UHA should describe if adult (MHSIP), family (YSS-F), and child (YSS) MH surveys and CAHPS surveys are used to gather member feedback and, if so, how it influences network adequacy related decisions.
17.	CCO describes how it uses technology to deliver team-based care and other innovations.	1	Met

Category Elements		Score	Findings/Recommendations
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**
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	0.5	**Findings**: UHA's narrative response described its relationships in depth with the Douglas County Public Health Network, DHS APD, and Douglas County Senior Services; however, the CCO briefly mentioned its membership with the Assessment, Feedback, Incentives, and Exchange program; IHS and/or Tribal Health Clinics; the Southwest Regional Health Collaborative Advisory Group; and the local MH authority, and the information was limited and did not describe its relationship with these stakeholders. UHA acknowledged and described its MOU with APD and AAA; however, the CCO did not specifically address whether an MOU was in place with the Douglas County Public Health Network, the local MH authority, and IHS and/or Tribal Health Clinics. **Recommendation for the Next Submission:** UHA should describe its relationship with the mentioned community stakeholders and the status of any memoranda of understanding. If a MOU is not in place, UHA should describe its efforts to implement one as it pertains to each applicable stakeholder.

Category Elements		Score	Findings/Recommendations
21.	CCO discusses coordination with above stakeholders.	0.5	**Findings**: UHA's narrative response described coordinating care with the Douglas County Public Health Network and AAA/APD. The CCO's mention of membership with the Assessment, Feedback, Incentives, and Exchange program IHS and/or Tribal Health Clinics, the Southwest Regional Health Collaborative Advisory Group, and the Local MH authority was limited and did not address the CCO's relationship with these stakeholders. UHA acknowledged and described its MOU with APD and AAA; however, the CCO did not specifically address whether a MOU was in place with the Douglas County Public Health Network, the local MH authority, and IHA and/or Tribal Health Clinics. **Recommendation for the Next Submission:** UHA should describe its relationship with the mentioned community stakeholders and the status of any MOU. If an MOU is not in place, UHA should describe its efforts to implement one as it pertains to each applicable stakeholder.
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.	0.5	**Findings**: UHA's narrative response described the CCO's two forms of interdisciplinary care teams, internal and community. Although the CCO described the goals of each team and reported a reduction in hospital readmission, UHA's response did not describe its process and/or methodology for analyzing the use of IDCTs to coordinate services and if the CCO considers the reported reduction in hospital readmission adequate. Additionally, the CCO did not describe if the IDCT meetings and efforts were adequate to reduce overall hospital readmission and emergency room visits. **Recommendation for the Next Submission:**

Category Elements		Score	Findings/Recommendations
			UHA should discuss its process and/or methodology for analyzing the use of IDCTs to coordinate services and if the CCO considers the reported reduction in hospital readmission adequate. Additionally, the CCO did not describe if the IDCT meetings and efforts were adequate to reduce overall hospital readmission and emergency room visits.
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	**3.5**	**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**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of UHA's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Douglas County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards. All of the ZIP Codes within UHA's service area are classified as rural. No deficiencies were assessed, validating that 90 percent of UHA's adult and pediatric members had access to all required provider service categories.

Provider Network Quality and Count Results

UHA submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was good with a few data quality issues. The following area of concern was observed in UHA's report:

- Of all the data records submitted, no providers had the Address #2 data field populated. The CCO included suite numbers and other "secondary" address information as part of the Address #1 values.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 795 individual practitioner and 641 facility/business/service provider data records of contracted providers. Table B-28 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of UHA's DSN Provider Capacity Report submission:

- Of the 795 total counted individual practitioners, all data records were identified as contracted and in-network providers. The geographic distribution of the data records was 548 in Douglas County, 245 in four counties that border the CCO's service area, and the remaining two providers in one non-bordering county.
- Of the 641 total counted facility/business/service providers, all data records were identified as contracted and in-network providers. The geographic distribution of the data records was 54 in Douglas County, 155 in six counties that border the CCO's service area, and the remaining 432 providers in 27 non-bordering counties. A majority of the 432 across the state were Pharmacies data records.
- No Certified or Qualified Health Care Interpreters individual practitioner data records were populated.
- Of the 70 SUD Provider data records identified as contracted and in-network providers, only one was also identified as a provider speaking a non-English language.
- The one Traditional Health Workers data record identified as a contracted and in-network provider was not identified as a provider speaking a non-English language.

- Of the two Health Education, Health Promotion, Health Literacy data records identified as contracted and in-network providers, neither was identified as speaking a non-English language.
- Of the two Palliative Care data records identified as contracted and in-network providers, neither was identified as speaking a non-English language.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-28—Individual Practitioner and Facility/Business/Service Provider Counts for UHA

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	153	19.2%	153	19.2%	0	0.0%
Specialty Provider	308	38.7%	308	38.7%	0	0.0%
Oral Health Provider	91	11.4%	91	11.4%	0	0.0%
MH Provider	168	21.1%	168	21.1%	0	0.0%
SUD Provider	70	8.8%	70	8.8%	0	0.0%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%	0	0.0%
Traditional Health Workers	1	0.1%	1	0.1%	0	0.0%
Health Education, Health Promotion, Health Literacy	2	0.3%	2	0.3%	0	0.0%
Palliative Care	2	0.3%	2	0.3%	0	0.0%
Overall	**795**	**100.0%**	**795**	**100.0%**	**0**	0.0%
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	1	0.2%	1	0.2%	0	0.0%
Ambulance and Emergency Medical Transportation	3	0.5%	3	0.5%	0	0.0%
Federally Qualified Health Centers	7	1.1%	7	1.1%	0	0.0%
Home Health	1	0.2%	1	0.2%	0	0.0%
Hospice	2	0.3%	2	0.3%	0	0.0%
Hospital	5	0.8%	5	0.8%	0	0.0%
Imaging	8	1.2%	8	1.2%	0	0.0%
Indian Health Service and Tribal Health Services	2	0.3%	2	0.3%	0	0.0%
MH Crisis Services	3	0.5%	3	0.5%	0	0.0%
Community Prevention Services	4	0.6%	4	0.6%	0	0.0%
Non-Emergent Medical Transportation	4	0.6%	4	0.6%	0	0.0%
Pharmacies	587	91.6%	587	91.6%	0	0.0%
Durable Medical Providers	6	0.9%	6	0.9%	0	0.0%

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Post-hospital Skilled Nursing Facility	1	0.2%	1	0.2%	0	—
Rural Health Centers	2	0.3%	2	0.3%	0	0.0%
School-based Health Centers	2	0.3%	2	0.3%	0	0.0%
Urgent Care Center	3	0.5%	3	0.5%	0	0.0%
Overall	**641**	**100.0%**	**641**	**100.0%**	**0**	0.0%

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Yamhill Community Care Organization

DSN Provider Narrative Evaluation Results

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 Polk and Washington counties.

The CCO submitted a DSN Provider Narrative Report with limited responses that lacked detail. YCCO's submission was accompanied with policies and procedures, sample member letters, provider handbook, member handbook, geo-location analysis, and time and distance calculations; however, the narrative response did not specifically reference which supporting documents apply to which elements.

YCCO's narrative response and a comprehensive policy and procedure together described how the CCO translates both member and provider full street addresses into geographic latitude and longitude coordinates to conduct geocoding to calculate the CCO's time and distance compliance. In addition to conducting geocoding analysis, YCCO had tools to conduct analysis and review geographic distribution of members to providers by ZIP Code, historical utilization, customer service request, complaint, and appeal data. The CCO discussed network adequacy and availability at various operations meetings and the Quarterly Clinical Advisory Panel meeting at a minimum quarterly. YCCO's policy clearly outlined the mechanisms in place for monitoring its delegated subcontractors to ensure member access and availability. YCCO's documented oversight activities included, but were not limited to, routine review of policies, analysis of received grievances and complaints, monitoring call center performance data, and appointment availability results.

YCCO operated a CHW Hub program and supported a peer support program run in partnership with a community agency. Members could be referred for assistance by network providers and community service agencies. The employed CHWs performed assessments on each member to identify social determinants of health and other member needs; develop an individualized plan with goals; and help connect members with case management, community resources, intervention, and self-advocacy programs. For example, members were connected with food or clothing banks; THWs to accompany members to appointments; and peer-led health and wellness programs specific to members and their families managing asthma, pain, diabetes, heart disease, and challenges with MH and SUDs.

YCCO described performing below the baseline on the *Childhood Immunization and Assessments for Children* in DHS Custody metrics. As an intervention, the CCO's provider relations team conducted two recruitment and contracting campaigns to address these areas of concern and build network capacity. YCCO specifically recruited providers to expand PCPCH capacity at the PCP clinic and individual practitioner levels. Additionally, YCCO sought to recruit and contract with clinics that were already enrolled with the federally funded VFC program that provides vaccines at no cost, immunizing and protecting babies, young children, and adolescents from illness and diseases.

Table B-29 provides the complete YCCO DSN Provider Narrative Report evaluation results.

Table B-29—YCCO—DSN Provider Narrative Report Evaluation Results

Category Elements		Score	Findings/Recommendations
Description of the 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.	0	**Findings**: YCCO's narrative response mentioned that analysis is done through the grievance system; however, the CCO did not specifically describe the activities conducted to monitor that appropriate availability to urgent, emergency, crisis, and triage services is available 24 hours a day/7 days a week for all members for physical, MU, SUD, and oral health services. Additionally, YCCO did not describe how activities are analyzed and whether the DSN is adequate for members to receive 24 hours a day/7 days a week access to appropriate care. **Recommendation for the Next Submission:** YCCO should describe activities conducted to monitor that appropriate availability to urgent, emergency, crisis, and triage services is available 24 hours a day/7 days a week for all members for physical, MU, SUD, and oral health services. The CCO should also describe how activities are analyzed and whether the DSN is adequate for members to receive 24 hours a day/7 days a week access to appropriate care.
4.	CCO analyzes wait times for appointments with providers, including specialists.	0.5	**Findings**: YCCO's narrative response described some of the activities and interventions in place to ensure timely access; however, the CCO did not address whether the DSN is adequate

Category Elements		Score	Findings/Recommendations
			for members to receive timely access to appointments with providers, including specialists. **Recommendation for the Next Submission:** YCCO should address whether the DSN is adequate for members to receive timely access to 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.	0.5	**Findings**: YCCO's narrative response and Network Capacity, Service Adequacy and Availability policy described how the CCO monitors time and distance access to specialists; however, the CCO did not address whether it considers member access to specialty care sufficient for members to receive timely access to care. **Recommendation for the Next Submission:** YCCO should address whether it considers member access to specialty care sufficient for members to receive timely access to care.
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**: YCCO's narrative response included the ratio of members to providers for PCPs, MH practitioners, SUD treatment providers, and dental care providers; however, the CCO did not address the ratio of members to specialists and the ratio of available acute care beds. Additionally, YCCO did not described its methodology or process for analyzing its member to provider calculated ratios. **Recommendation for the Next Submission:** YCCO should describe described its methodology or process and/or procedure for analyzing the ratio calculation. Additionally, the CCO should include the ratio of members to specialists and available acute care beds.

Category Elements		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**: YCCO's narrative response and THW policy and procedure described the types of THWs incorporated into its DSN; however, the CCO did not analyze the ratio of available THWs. Additionally, YCCO did not describe its process and/or procedure for monitoring and THWs by type or address whether member access to THWs is considered adequate. **Recommendation for the Next Submission:** YCCO should describe its process and/or procedure for monitoring and analyzing THWs by type and address whether member access to THWs 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.	0.5	**Findings**: YCCO's narrative response and NEMT policy and procedure described how NEMT services are provided to members across its DSN and monitored; however, the CCO did not address whether the CCO considers the services provided across its delivery system adequate. **Recommendation for the Next Submission:** YCCO should address whether its NEMT services provided across its delivery system are considered adequate.
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.	0.5	**Findings**: YCCO's narrative response and NEMT policy and procedure described how NEMT services are provided to members with disabilities or special needs; however, the CCO did not address whether its NEMT services for members with disabilities or special needs are considered adequate. **Recommendation for the Next Submission:** YCCO should address whether its NEMT services for members with disabilities or special needs are considered adequate.

Category Elements		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.	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.	0.5	**Findings**: YCCO's narrative response mentioned detox and intensive outpatient services available to adults and children and the lack of some SUD services available in Yamhill County. The CCO included its Behavioral Health Service policy and procedure that described the continuum of care for treatment of SUDs available; however, the CCO did not describe the entire continuum of care for treatment of SUDs and its process and/or procedure for monitoring and analyzing the treatment of SUDs. **Recommendation for the Next Submission:** YCCO should describe and demonstrate the entire continuum of care for treatment of SUDs and its process and/or procedure for monitoring and analyzing the treatment of SUDs.
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	**7.5**	**Out of Possible 12.0**

Category Elements		Score	Findings/Recommendations
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**: YCCO's narrative response mentioned that it takes into account member characteristics when assigning members to an appropriate provider; however, the CCO did not specifically describe its process and/or procedure for conducting analysis of the cultural, language, disability, and special health care needs of its membership. The CCO also did not submit analysis to demonstrate the characteristics of its membership's cultural, language, disability, and special health care needs. **Recommendation for the Next Submission:** YCCO should describe its process and/or procedure for conducting analysis of the cultural, language, disability, and special health care needs of its membership and submit analysis to demonstrate the characteristics of its membership's cultural, language, disability, and special health care needs.
14.	CCO provides analysis of the prevalence of diseases that require access to specialists among the member population.	0.5	**Findings**: YCCO's narrative response mentioned that the CCO's analytic team uses claims data to track prevalence of conditions; however, the CCO did not specifically described its process and/or procedure for conducting analysis of the prevalence of diseases that require access to specialists and did not submit analysis to demonstrate the prevalence of diseases within its membership that require access to specialists. **Recommendation for the Next Submission:** YCCO should describe its process and/or procedure for conducting analysis of the prevalence of diseases that require access to specialists and submit analysis to demonstrate the prevalence of diseases within its membership that require access to specialists.

Category Elements		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	**2.0**	**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 surveys; and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CCO needs to describe how it uses the input from its community advisory council.	0.5	**Findings**: YCCO's narrative response described providing CAHPS survey results to delegated entities and internal committees for the purpose of network adequacy decision making; however, the CCO did not specifically incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate how the CCO incorporates member feedback into network adequacy decisions. Additionally, the CCO described working with its CAC to obtain input for its member handbooks, website, and member information videos; however, the CCO did not address how it specifically solicits and incorporates CAC input into network adequacy decisions. **Recommendation for the Next Submission:** YCCO should incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate how the CCO incorporates member feedback into network adequacy decisions. The CCO should also address how it solicits and incorporates CAC input 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

Category Elements		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.	0.5	**Findings**: YCCO's narrative response described the availability of interpretation services furnished by Passport to Language for its providers and community partners to ensure that members have access to services in their preferred language; however, the CCO did not address how culturally appropriate services are made available to members. Additionally, YCCO did not address how its organization, including leadership and provider network, demonstrates its commitment to culturally and linguistically appropriate member services. **Recommendation for the Next Submission:** YCCO should describe how culturally appropriate services are made available to its members and how the organization, including leadership and provider network, demonstrates its commitment to culturally and linguistically appropriate member services.
	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.	0	**Findings**: YCCO's narrative response did not specifically address how the CCO collaborates with each of the above stakeholders to ensure coordination of member care. Additionally, the CCO did not incorporate examples, applicable scenarios, and/or supporting documentation to demonstrate how

Category Elements		Score	Findings/Recommendations
			the CCO coordinates member care with the above community stakeholders. **Recommendation for the Next Submission:** YCCO should describe how it coordinates care with the above stakeholders and include examples, applicable scenarios, and/or supporting documentation to demonstrate it.
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.	0.5	**Findings**: YCCO's narrative response included a brief statement about its MDT partnership, which included two large primary care practices and the local MH authority, and the role of the MDT within its oral health services; however, the CCO did not address how services are coordinated across the entire continuum of care. Additionally, YCCO expressed that its coordination services have been linked to a reductions in hospital admissions and ED use; however, the CCO did not describe its process and/or methodology for analyzing whether the use of interdisciplinary care teams to coordinate services is considered adequate. **Recommendation for the Next Submission:** YCCO should describe how services are coordinated across the entire continuum of care and its process and/or methodology for analyzing whether the use of interdisciplinary care teams to coordinate services is considered adequate.
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	**3.5**	**Out of Possible 5.0**

Category Elements		Score	Findings/Recommendations
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.	0.5	**Findings**: YCCO's narrative response briefly described that the Quality Clinical Advisory Panel, UM committee, and finance committee are involved with discussing and reviewing over- and underutilization; however, the CCO did not specifically address its process and/or procedures for analyzing patterns of both underutilization and overutilization. **Recommendation for the Next Submission:** YCCO should discuss its process and/or procedure for analyzing patterns of both over- and underutilizations.
	Total Score	**1.5**	**Out of Possible 2.0**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of YCCO's network of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover most of the CCO's service area (i.e., Yamhill County, and parts of Polk County and Washington County) based on the pre-defined time and distance thresholds (i.e., 30 miles/30 minutes and 60 miles/60 minutes) in alignment with OHA's current access standards, except for some member access to PCPCH providers across all counties within the service area.

All of the ZIP Codes within YCCO's service area are classified as a mix of urban and rural areas. As shown below in Figure B-26 and Figure B-27, the graphic representations illustrate urban and rural members without access to PCPCH practitioners and facilities within 30 and 60 miles/minutes. HSAG's analysis identified no PCPCH practitioners and facilities. All 20,508 (100 percent) members were without access within 30 miles/minutes in the CCO's service area. Likewise, 9,382 (100 percent) members were without access within 60 miles/minutes in the CCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of YCCO's service area.

Figure B-26—YCCO—Urban Members Without Access to PCPCH Practitioners and Facilities

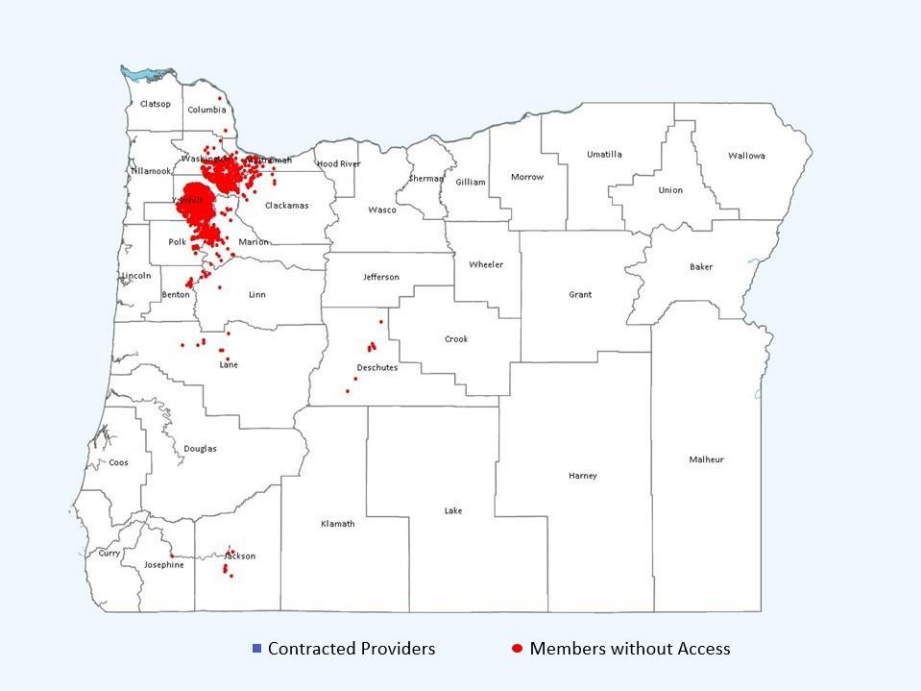
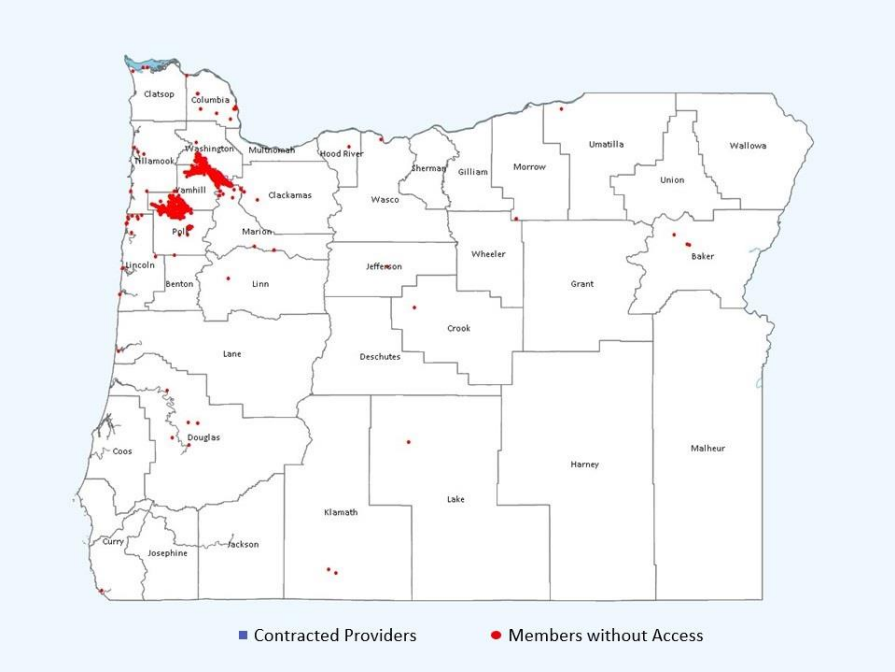


Figure B-27—YCCO—Rural Members Without Access to PCPCH Practitioners and Facilities



Provider Network Quality and Count Results

YCCO submitted a DSN Provider Capacity Report that contained all of the required data fields and accounted for both individual practitioners and facility/business/service providers. Overall, the quality of the CCO's DSN Provider Capacity Report was excellent with a few data quality issues. The following area of concern was observed in YCCO's report:

- Of the records submitted, only 91.6 percent had values populated in the Credentialing Date data field.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 8,833 individual practitioner and 759 facility/business/service provider data records of contracted providers. Table B-30 exhibits the results of contracted providers stratified by network status and provider service category throughout all counties in Oregon. Additionally, below are observations and areas of concern identified in the analysis results of YCCO's DSN Provider Capacity Report submission:

- Of the 8,833 total counted individual practitioners, 8,530 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 92 in Polk County, 2,225 in Washington County, 748 in Yamhill County, 5,464 in three counties that border the CCO's service area, and the remaining one in a non-bordering county.
- Of the 759 total counted facility/business/service providers, 191 data records were identified as contracted and in-network providers. The geographic distribution of the data records was 13 in Polk

County, 80 in Washington County, 25 in Yamhill County, 64 in six counties that border the CCO's service area, and the remaining nine in seven non-bordering counties.

- No Certified or Qualified Health Care Interpreters; Health Education, Health Promotion, Health Literacy; or Palliative Care individual practitioner data records were populated.
- No Ambulance and Emergency Medical Transportation, Indian Health Service and Tribal Health Services, MH Crisis Services, Community Prevention Services, Non-Emergent Medical Transportation, School-based Health Centers, or Urgent Care Center facility/business/service provider data records were populated.
- Two Federally Qualified Health Centers data records were populated; however, neither was identified as a contracted and in-network provider.
- The PCP, Specialty Provider, Oral Health Provider, MH Provider, and SUD Provider service categories demonstrated contracted and in-network providers that render care to both adult and pediatric members.

Table B-30—Individual Practitioner and Facility/Business/Service Provider Counts for YCCO

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
Individual Practitioners						
PCP	1,308	14.8%	1,308	15.3%	0	0.0%
Specialty Provider	6,489	73.5%	6,462	75.8%	27	8.9%
Oral Health Provider	65	0.7%	65	0.8%	0	0.0%
MH Provider	645	7.3%	463	5.4%	182	60.1%
SUD Provider	282	3.2%	193	2.3%	89	29.4%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%	0	0.0%
Traditional Health Workers	44	0.5%	39	0.5%	5	1.7%
Health Education, Health Promotion, Health Literacy	0	0.0%	0	0.0%	0	0.0%
Palliative Care	0	0.0%	0	0.0%	0	0.0%
Overall	**8,833**	**100.0%**	**8,530**	**100.0%**	**303**	**100.0%**
Facility/Business/Service Providers						
Hospital, Acute Psychiatric Care	14	1.8%	5	2.6%	9	1.6%
Ambulance and Emergency Medical Transportation	0	0.0%	0	0.0%	0	0.0%
Federally Qualified Health Centers	2	0.3%	0	0.0%	2	0.4%
Home Health	14	1.8%	14	7.3%	0	0.0%
Hospice	13	1.7%	13	6.8%	0	0.0%
Hospital	16	2.1%	16	8.4%	0	0.0%
Imaging	5	0.7%	5	2.6%	0	0.0%
Indian Health Service and Tribal Health Services	0	0.0%	0	0.0%	0	0.0%

	All Providers		Contracted, In-Network Providers		Contracted, Out-of-Network Providers	
Service Category[1]	Number	Percent[2]	Number	Percent[2]	Number	Percent[2]
MH Crisis Services	0	0.0%	0	0.0%	0	0.0%
Community Prevention Services	0	0.0%	0	0.0%	0	0.0%
Non-Emergent Medical Transportation	0	0.0%	0	0.0%	0	0.0%
Pharmacies	647	85.2%	90	47.1%	553	98.0%
Durable Medical Providers	8	1.1%	8	4.2%	0	0.0%
Post-hospital Skilled Nursing Facility	36	4.7%	36	18.8%	0	0.0%
Rural Health Centers	4	0.5%	4	2.1%	0	0.0%
School-based Health Centers	0	0.0%	0	0.0%	0	0.0%
Urgent Care Center	0	0.0%	0	0.0%	0	0.0%
Overall	**759**	**100.0%**	**191**	**100.0%**	**564**	**100.0%**

[1] Limited to providers in Oregon.
[2] '—' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Appendix C. CCO Plan Names

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