Oregon Health Authority
Health Services Division

2020 Delivery System Network Evaluation of Oregon Dental Care Organizations

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HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

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 five stand-alone dental care organizations (DCOs) to deliver oral health care services for Oregon Health Plan (OHP) 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 DCO 2.0 Contract Exhibit G(2). While each DCO 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 DCOs 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 Annual DCO 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 DCO 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 DCO 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 DCO results, and recommendations to the State are included in this 2020 DCO 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 DCO DSN Evaluation Report Objective

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

1. A comprehensive summary of evaluation results, including general assessments.
2. Findings and required actions for each DCO to achieve OHA network adequacy standards.
3. 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 DCOs 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 three categories based on OHA's DCO contract requirements. Each category includes corresponding elements that require the DCOs to describe and submit comprehensive narrative responses and analysis demonstrating how the DCOs 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. DCOs 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 DCO's DSN is subcontracted or delegated, the DCO 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 DCO's overall DSN, and how the DCO monitors its delegated providers, ensuring compliance with federal and State provider network requirements. Table 1-1 identifies the three DSN Provider Narrative Report categories, the number of reporting elements associated with each category, and the maximum number of points possible for scoring the DCOs' 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	6
2	Description of Members	3
3	Additional Analysis of the DCO's Provider Network to Meet Member Needs	5

DSN Time and Distance Report

The DSN Provider Narrative Report additionally requires each DCO to document its compliance with OHA's travel time and distance standards pursuant to OAR 410-141-3515. DCOs 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 distance, as listed in Table 1-2 below. DCOs used the precise location of the closest participating DSN provider and the member's address to calculate the DCO's time (minutes) and distance (miles) standards. DCOs calculated member travel time and distance based on the provider types identified in the *2020 Annual DCO 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

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

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 DCO's report submission and lead to required resubmission.

HSAG processed, cleaned, and evaluated the data to assess the general capacity of each DCO's compliance with the required provider file layout as outlined in the *2020 Quarterly DSN Provider Capacity Report Instructions*. Specifically, HSAG evaluated each DCO'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., adult and pediatric primary care dentists [PCDs], expanded practice dental hygienists [EPDHs], and oral health specialists).

DSN Provider Narrative Report Evaluation and Scoring

HSAG evaluated each DCO'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 14.0 total points was possible across all three 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	6	6.0
2	Description of Members	3	3.0
3	Additional Analysis of the DCO's Provider Network to Meet Member Needs	5	5.0
	Totals	**14**	**14.0**

HSAG evaluated the time and distance reported in the DSN Provider Narrative Report to assess each DCO's ability to meet contract standards related to members' access to providers.[2-1] DCOs 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 DCOs' 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 DCO'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 DCO's ability to comply with the initial quarterly DSN submission requirements. Initial target review results were communicated to the DCOs 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 DCO's report submission and lead to required resubmission.

Using the DCOs' 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 DCO'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 Capacity	The underlying infrastructure of the DCO'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 DCO'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 DCO's DSN based on pre-defined time and distance thresholds, by provider specialty/category.

Overall DSN Provider Narrative Report Evaluation Results

Overall, the DCOs received a score of 10.8 points across aggregated DSN Provider Narrative Report categories, or approximately 77 percent of the maximum points possible (14.0 points), as shown in Table 3-1 below. Two DCOs achieved a perfect score in at least one category. All DCOs received at least a positive score in each category. While all DCOs earned their lowest scores in the *Description of Members* category, all put in their strongest or tied-for-strongest performance and/or a perfect score in the *Additional Analysis of the DCO's Provider Network to Meet Member Needs* category. CY 2020 represents the first year DSN Provider Narrative Reports were required of DCOs; therefore, some of the lower scores more likely represent a need for technical assistance rather than failings on the part of the DCOs. Two of the DCOs, CDC and MDCO, are sister-DCOs, having mostly separate provider pools, service areas, and membership, but sharing policies, procedures, and central/executive staff. They are reported separately.

Table 3-1—DSN Provider Narrative Report Evaluation Results

DCO Name*	DSN Provider Narrative Report Categories			Total DCO Score
	Description of the Delivery Network and Adequacy	Description of Members	Additional Analysis of the DCO's Provider Network to Meet Member Needs	
ADS	3.0	2.0	4.0	9
CDC	4.0	2.5	4.5	11
FDCi	4.0	1.0	5.0	10
MDCO	4.0	2.5	4.5	11
ODS	6.0	2.0	5.0	13
Statewide Average Scores	**4.2**	**2.0**	**4.6**	**10.8**
Points Possible	**6.0**	**3.0**	**5.0**	**14.0**

* Please see Appendix C for a list of full DCO 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 DCO's providers relative to the geographic distribution of its membership, as well as the DCO's ability to meet time and distance standards in addition to member-to-provider ratios for adult and pediatric PCDs, EPDHs, and oral health specialists. This category also required each DCO to define its method of geocoding and analysis. Additional elements that the DCOs had to address included membership access to services 24 hours a day, seven days a week; appointment wait times; and use of telemedicine or video conferencing for specialist consultations to eliminate gaps in care.

DCO Results

One DCO met all of the elements in the *Description of the Delivery Network and Adequacy* narrative category. Three DCOs met the majority of elements in the category. One DCO met less than half of the elements in the category; based on the nature of the DCO's narrative submission and estimated size of its network, the DCO likely meets the majority of elements in practice, but would greatly benefit from technical assistance for reporting.

Only one DCO fully identified the geocoding application or software (Facets and Quest Analytics) used in its network analysis. Four of the five DCOs calculated time and distance standards in a way that did not explicitly use the precise physical address of both the member and provider or did not fully describe their methodology. Measuring with non-precise locations (e.g., ZIP Codes or counties) produces inaccurate estimates of routine travel time and distance.

All DCOs exhibited a strength in the category in terms of monitoring member access to care and ensuring provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day, seven days a week. Oregon's DCOs were uniformly committed to and capable of providing appropriate dental care to members when they needed it.

Conclusions

HSAG concluded that there are opportunities for technical assistance in terms of expectations and requirements for how time and distance standards are calculated, analyzed, and reported. 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 delivery network. Standardization of reporting by all DCOs would further support OHA's oversight of DSN, as described in OAR 410-141-3220.

Recommendations

HSAG has the following recommendations for the DCOs:

- Secure a geocoding application or software, develop strategies, and implement mechanisms 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, also ensuring that at least 90 percent of the membership can access health care within each DCO's delivery system network.
- Design and implement ongoing monitoring mechanisms and strategies to track and evaluate members' access to care, including appointment wait times.
- Develop and implement standard categorization of providers based on the member populations served by the DCOs and use those provider categories to evaluate member-to-provider ratios for key oral health provider types (e.g., PCDA, PCDP, EPDH, and oral health specialist).
- Follow all specifications outlined in the *2020 Annual DCO DSN Provider Narrative Report Instructions*, including complete and comprehensive narrative responses and all required analysis for the corresponding elements in this category.

Description of Members

The *Description of Members* category contained elements that required each DCO to describe its ability to identify and analyze the needs of its members. More specifically, each DCO was required to demonstrate its ability to identify and analyze the cultural, language, and disability, and special health care needs of its membership and use this information to assign members to appropriate PCDs.

DCO Results

The *Description of Members* category yielded low scores for all DCOs, representing the worst category for four out of five DCOs. No DCO submitted a cultural, language, disability, and special health care needs analysis demonstrating characteristics of its membership, nor described analyzing all listed characteristics as part of its membership analysis processes. Some DCOs described analyzing their membership population in terms of language. Most DCOs reported relying on their Member Services or Care Coordination Team/care coordinator(s) for the purposes of helping members find a "best fit" member/provider assignment. One DCO described assigning members by ZIP Code and providing members with a "provider search tool," but did not describe the process further, how it benefited members, or how it considered the needs of members in making assignments.

Conclusions

Evaluation results indicated that the DCOs should conduct more comprehensive analyses of the cultural, language, disability, and special health care needs of members when assessing the adequacy of networks. The lack of consistent and complete provider data and supplemental documentation, including the inaccurate completion of the 2020 Annual DCO DSN Provider Narrative Report Template, made it difficult to assess and compare performance across DCOs. Standardization of reporting by all DCOs would further support both the DCOs' and OHA's oversight of delivery system networks. Improving the quality of member data and information is especially important when conducting cross-sectional analyses of DCOs contracted in overlapping geographic service areas.

Recommendations

Based on the conclusions above and submitted documentation, HSAG has the following recommendations for the DCOs:

- Develop and implement processes to ensure the collection of supplemental member data (e.g., cultural, language, disability, and special health care needs) to support the monitoring and reporting of member needs.
- Develop reports and internal metrics for assessing the adequacy of the DCOs' delivery system networks relative to key member characteristics.
- Follow all specifications outlined in the *Annual DCO DSN Provider Narrative Report Instructions*, including complete and comprehensive narrative responses and all required analysis for the corresponding elements in this category.

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

The *Additional Analysis of the DCO's Provider Network to Meet Member Needs* category contained elements for which the DCOs described their process for incorporating member feedback (including complaints and grievances) into network adequacy decisions. In addition, DCOs 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 DCOs operationalized their commitment to making culturally and linguistically appropriate services available to members within the organization, including DCO leadership.

DCO Results

All DCOs turned in their strongest or tied-for-strongest performance in the *Additional Analysis of the DCO's Provider Network to Meet Member Needs* category. Two DCOs earned a perfect score in the category, and all DCOs showcased one or more major and innovative strengths in the category, including such approaches as technology use, development, and investment; health equity training and analysis; sophisticated and dedicated member outreach and care coordination; and community investment or program pilots. The main opportunity for improvement for DCOs in this category was in submitting narratives that did not contain full responses, detailed examples, and/or relevant supporting documentation, all of which points to a likely need for technical assistance in appropriate reporting rather than failings in their respective networks. The most common finding for DCOs was not including concrete examples of incorporating member feedback when making network decisions and assessing adequacy.

Conclusions

Drawing on the narrative responses, HSAG concluded that DCOs would benefit from technical assistance in providing all necessary information during reporting. Based on the evidence provided, HSAG could not determine whether and how DCOs were making concerted efforts to incorporate member feedback when making network decisions and assessing adequacy, including through the implementation of member-focused surveys. Some DCOs stated that they used the member grievance process to inform their network decisions or assess adequacy but did not provide examples.

Recommendations

Based on the conclusion presented above, HSAG has the following recommendations for the DCOs:

- Develop mechanisms to collect member feedback from existing data sources (e.g., member surveys) and incorporate the information into network adequacy analyses in order to support network management decisions.
- Develop and implement new mechanisms (e.g., surveys, stakeholder meetings, member forums, etc.) to collect information on member feedback.
- Improve the quality of information reported in the DCO narratives to better demonstrate how the DCOs use member feedback in making network decisions and assessing network adequacy.

Time and Distance Standards Reporting

Overall, the DCOs received a score of 4.0 points across aggregated DSN Provider Narrative Report—Time and Distance Standards, or approximately 80 percent of the maximum points possible (5.0 points), as shown in Table 3-2 below.

Table 3-2—DSN Provider Narrative Report Evaluation Results

DCO Name*	DSN Provider Narrative Report—Time and Distance Standards**					Total DCO Score
	PCDA	PCDP	EPDH	OHSA	OHSP	
ADS	1.0	1.0	1.0	1.0	1.0	5.0
CDC	1.0	1.0	1.0	1.0	1.0	5.0
FDCi	0.0	0.0	0.0	0.0	0.0	0.0
MDCO	1.0	1.0	1.0	1.0	1.0	5.0
ODS	1.0	1.0	1.0	1.0	1.0	5.0
Statewide Average Scores	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**4.0**
Points Possible	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**5.0**

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

DCO Results

As a result of the guidance provided, the DCOs demonstrated DSN time and distance compliance by reporting the time and distance standards in minutes, miles, and percent of overall member access for each geographic classification for their service area distance; this section was scored solely based on the DCOs' ability to report values within the standard for their geographic classification for all required service categories. Additionally, the *2020 Quarterly DCO DSN Provider Capacity Report Instructions* included EPDH as an all-inclusive provider service category; however, the 2020 Annual DCO DSN Provider Narrative Report Template time and distance reporting included EPDH stratified for adults and children. Upon discussing with OHA, it was decided after the instructions were dispersed that this service category would not be stratified and all reporting for EPDH would be comprehensive.

Four of the five DCOs met all of the elements in the *Time and Distance Standards Reporting* section of the narrative. DCO compliance was demonstrated by reporting routine time or distance (i.e., minutes and miles) and the percentage of members with access to services based on their corresponding geographic classification 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.

One of the four DCOs provided detailed time and distance standards with variations in minutes, miles, and percentages, demonstrating the DCOs calculated member travel time and distance, and percentage of members with access in their service area. Two of the four DCOs reported their routine time and distance standard to mirror the 30 and/or 60 miles and minutes, and the percentage of members with access was described as, "No difference from OAR standards." The remaining DCO reported its routine time and distance as the standard 30 and 60 miles and minutes, and 90 percent of members with access in its service area with no variation, across all required service categories.

As for the one DCO that did not meet any of the time and distance standards, only the average driving distance was reported for PCDA and PCDP in miles. The DCO also did not specify whether the standard was for the rural or urban geographic classification. Additionally, the DCO included, "the ratio of EPDHs to members changes depending on the specific clinic's staffing mix" response time, distance, and percentage of members with access reporting.

Conclusions

Evaluation results indicated that the DCOs 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. DCOs should conduct more comprehensive time and distance analyses, ensuring that each member's routine time and distance to a participating provider's location does not exceed the OHA standard for accessing care from providers within the delivery network. Standardization of reporting by all DCOs would further support both the DCOs' and OHA's oversight of delivery system networks.

Recommendations

Based on the conclusions presented above, HSAG has the following recommendations for the DCOs:

- Develop and implement reporting mechanisms for assessing the routine time and distance standard, measuring 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 DCO's delivery system network.
- Develop and implement standard categorization of providers based on the member populations (e.g., adult and pediatric) served by the DCOs and use those service categories to evaluate time and distance that includes PCDs and oral health specialists).

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 that a majority of the DCOs did not rectify quality, consistency, and accuracy issues identified as part of the one-time Targeted DSN Provider Capacity Report Review. Below are the observed reporting exceptions:

- Three of the five DCOs 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. All three DCOs resubmitted a DSN Provider Capacity Report with no data records identified as Provider Category Description of Facility "03" or Business or Healthcare Services "04."
- Two of the five DCO's DSN Provider Capacity Reports demonstrated more complete and accurate provider network data; however, deficiencies with data field values and format were still observed.

Provider Network Count

HSAG processed, cleaned, deduplicated, and assessed each DCO's third quarter DSN Provider Capacity Report, identifying the number and percent of oral health 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).

- Three of the five DCOs submitted its DSN Provider Capacity Report with no data records identifying the Provider Category Description of Facility "03" or Business or Healthcare Services "04."
- After deduplication by NPI, two of the five DCOs were assessed as having less than 25 percent of their contracted and in-network PCDs rendering care to pediatric members.
- None of the five DCOs submitted DSN Provider Capacity Reports with populated data records for all eleven oral health practitioner service categories.

Provider Accessibility

HSAG assessed the provider accessibility of each DCO, identifying the total number of PCDs (e.g., PCDA and PCDP) accepting new members. Table 3-3 exhibits deduplication of PCDs by National Provider Identifier (NPI) and results stratified by contract and network status.

- Three of the five DCOs were assessed as having greater than 95 percent of their total number of PCDs accepting new members.
- One of the five DCOs was evaluated as having a total number of 941 unique PCDs within its network, and only 557 providers (59.2 percent) were identified as accepting new members.

- One of the five DCOs was evaluated as having a total number of 761 unique PCDs within its network, with only 15.6 percent of the providers accepting new members.
- When comparing contracted, in-network PCDs accepting new members across all five DCOs, 1,034 out of 2,065 PCDs resulted in 50.1 percent accepting new members.

Table 3-3—Number and Percent of PCDs Accepting New Patients, by DCO

DCO[1]	All Providers			Contracted, In-Network PCDs		
	Number Accepting New Patients	Total Number of PCDs	Percent	Number Accepting New Patients	Total Number of PCDs	Percent
ADS	119	761	15.6%	119	761	15.6%
CDC	241	244	98.8%	241	244	98.8%
FDCi	57	57	100.0%	56	56	100.0%
MDCO	61	63	96.8%	61	63	96.8%
ODS	557	941	59.2%	557	941	59.2%

[1] Limited to providers in Oregon.

Geographic Distribution

The geographic distribution of providers relative to member populations assessed whether or not the oral health practitioners 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.

- Three of the five DCOs 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 DCO's service area and corresponding ZIP Codes.
- Two of the five DCOs' geographic distribution of EPDHs compared to their memberships were not sufficient to cover each DCO'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 of both DCOs' DSN Provider Capacity Reports identified that neither report included any data records for EPDHs, validating that 100 percent of both memberships were without access.
- Four of the five DCOs were assessed to have membership residing in counties and ZIP Codes that did not align with the OHA-defined geographic service areas.

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 and the OHA 2020 Health Plan Services DCO Contract, Exhibit G(2). Below are several recommendations based on identified opportunities for improvement to support enhancements to the monitoring, assessment, and reporting of network adequacy to OHA.

- **Align Category Elements With Requirements:** OHA should reevaluate the elements within the categories outlined in the 2020 Annual DCO 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 and the OHA 2020 Health Plan Services DCO Contract, Exhibit G(2); and OAR 410-141-3515, creating clear and concise elements that describe what is required of the DCO.
- **Establish Standardized Time and Distance Standards:** OHA should reevaluate the time and distance standard elements outlined in the 2020 Annual DCO 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 and the OHA 2020 Health Plan Services DCO Contract, Exhibit G(2); and OAR 410-141-3515, creating clear and concise elements that describe what is required of the DCO.
- **Define Urban and Rural Geographic Classifications:** OHA should reevaluate the definitions of "urban" and "rural" geographic area classifications in the 2020 Annual DCO DSN Provider Narrative Report Template to ensure alignment with both the routine travel time and distance standards in accordance with 42 CFR §438.206 and §438.207 and OHA 2020 Health Plan Services DCO Contract, Exhibit G(2); and OAR 410-141-3515, creating clear and concise elements that describe what is required of the DCO.
- **Eliminate Independent Time and Distance Standards Reporting:** OHA should reevaluate whether the independent time and distance standard reporting section incorporated in the 2020 Annual DCO DSN Provider Narrative Report Template can be eliminated. Instead, OHA should expand the time and distance standards reporting for the relevant *Description of the Delivery Network and Adequacy* category elements, eliminating duplicate efforts.
- **Technical Assistance:** OHA should promote and provide technical assistance to DCOs on expectations for DSN Provider Narrative Report response submissions and associated data analysis.

DSN Provider Capacity Report Recommendations

DCO adherence to clearer guidelines will result in the submission of more consistent and accurate oral health practitioner and facility inventories. Listed below are several recommendations for OHA to support more meaningful reporting of DCO provider network capacity.

- **Utilize the Standardized Healthcare Provider Taxonomy Code Set:** OHA should implement a time-limited work group to facilitate the adoption of the Healthcare Provider Taxonomy Code Set and eliminate the use historical OHA Medicaid Management Information System (MMIS) provider type and specialty type codes. The Taxonomy Code Sets are a Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard code set designed to categorize the type, classification, and/or specialization of health care providers and facilities. All oral health practitioners and facility/business/service providers are required to select the taxonomy code(s) that most closely describes the health care provider's type/classification/specialization when applying for an NPI.
- **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 dentist and oral health specialists), program-specific definitions, standardized provider and facility type specifications, and a sample PFL template.
- **Conduct DCO Training on Proper DSN Provider Capacity Reporting:** OHA should conduct training for all DCOs, provide detailed guidance on appropriate methods for submitting provider capacity information, and review the requirements for submitting provider capacity network data.
- **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 DCOs).
- **Evaluate DCO Member Assignment:** OHA should evaluate members that appear to reside in counties and ZIP Codes outside of the DCO's OHA-defined geographic service area.
- **Establish Compliance Expectations:** OHA should hold the DCOs accountable for timely, accurate, and complete data submissions. DCOs that submit documentation that does not conform to the new templates and submission requirements within an established time frame should be rejected until the DCO's data submission adheres to the template requirements.

Appendix A. DCO DSN Provider and Service Categories

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

Provider Category Value	Provider Category Description
01	Oral Health Practitioner
02	Other Oral Health Practitioner
03	Facility
04	Business or Healthcare Services

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

Service Category Value	Service Category Description
PCDA	Primary Care Dentist, Adult
PCDP	Primary Care Dentist, Pediatric
EPDH	Expanded Practice Dental Hygienist
ODO	Orthodontist & Dentofacial Orthopedics
OMS	Oral & Maxillofacial Surgeon
OMP	Oral & Maxillofacial Pathologist
PER	Periodontist
END	Endodontist
DEN	Denturist
PRO	Prosthodontics
RDH	Registered Dental Hygienist
GDC	General Dental Clinic
DOP	Dental Clinic, Pediatric
MDC	Mobile Dental Clinic
OAC	Orthodontics & Dentofacial Orthopedics Clinic
OMSC	Oral & Maxillofacial Surgery Clinic
EDSC	Emergency Dental Services Clinic
PCHD	Public/County Health Department
QHCI	Certified or Qualified Health Care Interpreters
FQHC	Federally Qualified Health Centers
IHS/THS	Indian Health Service and Tribal Health Services
RHC	Rural Health Centers
SHC	School-based Health Centers

Appendix B. DSN Evaluation and Analysis Results by DCO

Advantage Dental Services, LLC

DSN Provider Narrative Evaluation Results

Advantage Dental Services, LLC (ADS) contracts with OHA to provide oral health services to OHP members residing in Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, and Yamhill counties.

ADS performed very well in terms of both technological capability and membership outreach. The DCO submitted a DSN Provider Narrative Report with detailed responses for many elements but unfortunately did not submit relevant analyses or analyses with sufficient detail, which strongly impacted the results of the evaluation. ADS' narrative responses were generally not accompanied by supplemental documentation to further demonstrate how the DCO ensures, monitors, and evaluates the adequacy of its provider network.

ADS provided county-level data and global ratio data for members, PCDs, and other providers, which was not a sufficient resolution for the evaluation. The DCO also did not describe the geocoding application/software or methodology used to conduct a geographic distribution analysis.

ADS described a robust online provider directory, electronic monitoring and assignment system, utilization analysis process, member choice model, and care coordination apparatus. However, it was not clear if ADS' efforts around provider assignments were driven by formal analysis of its membership demographics, as ADS did not provide a cultural, language, disability, and special health care needs analysis of its membership. Additionally, the DCO did not provide evidence of its utilization management efforts.

ADS provided detailed descriptions of its commitment to a responsive, accessible, and state-of-the-art dental care system for its members. ADS' in-house care coordination portal "ADIN," participation in multiple e-health collaboratives and programs, and proactive member communications regarding specific dental health care needs were notable strengths. The DCO did not describe its process and/or procedure for incorporating complaint and grievance analysis into network adequacy decisions.

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

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

Category Elements		Score	Findings/Recommendations
Description of the Delivery Network and Adequacy			
1.	DCO describes the geographic distribution of all providers compared with the geographic distribution of members. The DCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	0	**Findings:** ADS provided county-level counts of members, PCDs, and providers, which was not a sufficiently detailed scale for reporting. Additionally, the DCO did not describe the geocoding application or software used to conduct the analysis, only referencing an "interactive electronic PCD assign tool." The DCO's analysis did not provide an evaluation of the network's adequacy as it related to the geographic distribution of members and providers. **Recommendation for the Next Submission:** ADS should provide a DSN analysis that uses the precise physical address-level locations of providers and members to determine geographic network adequacy. ADS should also describe the geocoding application or software used to conduct the analysis.
2.	DCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0	**Findings:** ADS did not provide analysis of time and distance standards for its service area. The DCO stated that member access time and distance standard compliance was monitored monthly through the member assignment review process. **Recommendation for the Next Submission:** ADS should provide a DSN analysis that uses the precise physical address-level locations of providers and members to determine geographic network adequacy per the time and distance standards. ADS should also describe the process and/or procedure for the analysis. The DCO should also describe what actions it takes or is prepared to take to rectify any instance of noncompliance.

Category Elements		Score	Findings/Recommendations
3.	DCO 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.	DCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	DCO discusses how the network ensures time and distance standards for member access to specialists. DCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	0.5	**Findings:** ADS stated that the major specialties for Medicaid services were oral surgery and endodontics but did not describe how that need was assessed. The DCO also stated that it strove to have at least one contracted specialist in oral surgery and endodontics in every "region," but described neither how "region" was defined nor whether and how that was determined to be adequate. **Recommendation for the Next Submission:** ADS should provide an analysis of its network and membership regarding network adequacy for access to specialists and specialist services, as well as the methodology for the analysis.
6.	DCO describes the ratio of members to providers for PCDs, EPDHs, and Oral Health Specialists. DCO addresses ratios for pediatric, adult, and geriatric providers. The DCO should analyze these ratios and describe whether the DCO considers these ratios adequate.	0.5	**Findings:** ADS described a model assignment of 3,000 members per dentist and a global dentist to member ratio of 1:88, as well as the number of specialists available globally. However, the DCO did not provide any description of geographic relationship or adequacy. **Recommendation for the Next Submission:** ADS should provide an address-level geographic analysis of its network (rather than global) and membership regarding network adequacy for access to specialists and specialist services, as well as the methodology for the analysis.
	Total Score	**3.0**	**Out of Possible 6.0**

Category Elements		Score	Findings/Recommendations
Description of Members			
7.	DCO describes its process for taking into account member characteristics when making provider assignments. • DCO provides analysis of the language and cultural needs of members. • DCO provides analysis of the needs of members with disabilities and members with special health care needs.	0.5	**Findings:** ADS did not provide a cultural, language, disability, and special health care needs analysis of its membership. **Recommendation for the Next Submission:** ADS should provide a cultural, language, disability, and special health care needs analysis of its membership.
8.	DCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
9.	DCO analyzes patterns of underutilization and overutilization and the actions the DCO has taken to address underutilization and overutilization.	0.5	**Findings:** ADS described its process for analyzing patterns of underutilization and overutilization. However, the DCO did not provide examples, applicable scenarios, and/or supporting documentation to demonstrate actions taken to address underutilization and overutilization (e.g., a PCD Utilization Report). **Recommendation for the Next Submission:** ADS should describe its process and/or procedure for analyzing patterns of underutilization and overutilization. The DCO should provide examples, applicable scenarios, and/or supporting documentation to demonstrate actions taken to address underutilization and overutilization.
	Total Score	**2.0**	**Out of Possible 3.0**

Category Elements		Score	Findings/Recommendations
Additional Analysis of the DCO's Provider Network to Meet Member Needs			
10.	DCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis.	0	**Findings:** ADS did not describe how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, nor did the DCO provide examples of doing so. **Recommendation for the Next Submission:** ADS should describe how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis. The DCO should also provide examples of doing so.
11.	DCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
12.	DCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	1	Met
13.	DCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The DCO should address all levels within the organization, including leadership and provider network.	1	Met
14.	DCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	1	Met
	Total Score	**4.0**	**Out of Possible 5.0**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of ADS' network of oral health practitioners compared to its membership was sufficient to cover the DCO's service area (i.e., Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, and Yamhill 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. All of the ZIP Codes within ADS' service area represent a mix of urban and rural geographic classifications. No deficiencies were assessed, validating that 90 percent of ADS' adult and pediatric members had access to all required provider service categories.

Provider Network Quality and Count Results

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

- Of all the PCD data records submitted, only 5.4 percent of the oral health practitioners had a value populated in the # of Members Assigned to PCDs data field.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 1,786 oral health practitioner and 173 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 ADS' DSN Provider Capacity Report submission:

- Of the 1,786 total counted oral health practitioners, all data records were identified as contracted and in-network providers. The geographic distribution of in-network data records was two in Baker County, 55 in Benton County, 68 in Clackamas County, 23 in Clatsop County, 26 in Columbia County, 74 in Coos County, 49 in Crook County, 43 in Curry County, 118 in Deschutes County, 165 in Douglas County, two in Gilliam County, 37 in Grant County, 16 in Harney County, 13 in Hood River County, 114 in Jackson County, 42 in Jefferson County, 70 in Josephine County, 38 in Klamath County, 21 in Lake County, 166 in Lane County, 53 in Lincoln County, 62 in Linn County, 32 in Malheur County, 95 in Marion County, 39 in Morrow County, 109 in Multnomah County, 37 in Polk County, zero in Sherman County, 57 in Umatilla County, 19 in Union County, zero in Wallowa County, 41 in Wasco County, 88 in Washington County, five in Wheeler County, six in Yamhill County, and one in Tillamook County that borders several counties within ADS' service area.
- Of the 173 total counted facility/business/service providers, 172 data records were identified as contracted and in-network providers. The geographic distribution of in-network data records was

zero in Baker County, six in Benton County, five in Clackamas County, one in Clatsop County, three in Columbia County, eight in Coos County, four in Crook County, one in Curry County, 19 in Deschutes County, 10 in Douglas County, one in Gilliam County, one in Grant County, one in Harney County, two in Hood River County, 11 in Jackson County, three in Jefferson County, nine in Josephine County, five in Klamath County, one in Lake County, 17 in Lane County, four in Lincoln County, five in Linn County, eight in Malheur County, 11 in Marion County, one in Morrow County, 9 in Multnomah County, four in Polk County, zero in Sherman County, four in Umatilla County, five in Union County, zero in Wallowa County, four in Wasco County, five in Washington County, one in Wheeler County, and three in Yamhill County.

- No Oral & Maxillofacial Pathologist, Prosthodontics, or Registered Dental Hygienist oral health practitioner data records were populated.
- No Emergency Dental Services Clinic, Public/County Health Department, Certified or Qualified Health Care Interpreters, or Indian Health Service and Tribal Health Services facility/business/service provider data records were populated.
- Of the 338 total counted Expanded Practice Dental Hygienist data records, none were identified as practitioners speaking a non-English language.
- Of the 12 total counted Periodontist data records, none were identified as practitioners speaking a non-English language.
- After deduplication of Primary Care Dentist data records by NPI, 573 total contracted, in-network providers were identified. Of those data records, 266 (46.4 percent) were identified as Primary Care Dentist, Adult practitioners, and 307 (53.6 percent) were identified as Primary Care Dentist, Pediatric practitioners.

Table B-2—Oral Health Practitioner and Facility/Business/Service Provider Counts for ADS

	All Providers		Contracted, In-Network Providers	
Services Category[1]	Number	Percent[2]	Number	Percent[2]
Oral Health Practitioners				
Primary Care Dentist, Adult	634	35.5%	634	35.5%
Primary Care Dentist, Pediatric	719	40.3%	719	40.3%
Expanded Practice Dental Hygienist	338	18.9%	338	18.9%
Orthodontist & Dentofacial Orthopedics	10	0.6%	10	0.6%
Oral & Maxillofacial Surgeon	38	2.1%	38	2.1%
Oral & Maxillofacial Pathologist	0	0.0%	0	0.0%
Periodontist	12	0.7%	12	0.7%
Endodontist	12	0.7%	12	0.7%
Denturist	23	1.3%	23	1.3%
Prosthodontics	0	0.0%	0	0.0%
Registered Dental Hygienist	0	0.0%	0	0.0%
Overall	**1,786**	**100.0%**	**1,786**	**100.0%**

	All Providers		Contracted, In-Network Providers	
Services Category[1]	Number	Percent[2]	Number	Percent[2]
Facility/Business/Service				
General Dental Clinic	97	56.1%	96	55.8%
Dental Clinic, Pediatric	30	17.3%	30	17.4%
Mobile Dental Clinic	1	0.6%	1	0.6%
Orthodontics & Dentofacial Orthopedics Clinic	10	5.8%	10	5.8%
Oral & Maxillofacial Surgery Clinic	16	9.2%	16	9.3%
Emergency Dental Services Clinic	0	0.0%	0	0.0%
Public/County Health Department	0	0.0%	0	0.0%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%
Federally Qualified Health Centers	16	9.2%	16	9.3%
Indian Health Service and Tribal Health Services	0	0.0%	0	0.0%
Rural Health Centers	1	0.6%	1	0.6%
School-based Health Centers	2	1.2%	2	1.2%
Overall	**173**	**100.0%**	**172**	**100.0%**

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

Capitol Dental Care, Inc.

DSN Provider Narrative Evaluation Results

Capitol Dental Care, Inc. (CDC) contracts with OHA to provide oral health services to OHP members residing in Benton, Clackamas, Clatsop, Columbia, Crook, Deschutes, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Umatilla, Wasco, Washington, and Yamhill counties.

CDC submitted a DSN Provider Narrative Report with responses that largely met the requirements of both State access standards and DSN evaluation but left out some crucial details or did not explain some of its conclusions fully. CDC's strengths include its Member Services Team, proactive Quality Improvement Committee, round-the-clock accessibility monitoring, use of teledentistry, funding support of pilot programs, outreach to rural communities, and member touch-point education and outreach.

When describing its delivery network and network adequacy, CDC provided member counts showing exemplary compliance with State access standards. However, the DCO did not precisely identify the geocoding application or software used to conduct the analysis. Similarly, while CDC provided a count of its contracted PCDs and specialists, the DCO did not provide an analysis, methodology, or supporting documentation for determining that its ratio of members to PCDs and specialists was adequate—only a statement that it felt the ratios were adequate.

CDC described processes for and gave examples of leveraging its experienced Member Services Team to promote members' right to choose a provider and assist members in selecting a provider of good fit. Behind this effort was a process of periodic analysis of CDC's membership by language to better understand its membership demographics. However, no example analysis was provided, nor did the DCO provide an analysis of its cultural, disability, and special health care needs membership. Finally, the DCO did not provide examples, scenarios, and/or supporting documentation demonstrating how it incorporates member feedback into network adequacy decisions.

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

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

Category Elements		Score	Findings/Recommendations
Description of the Delivery Network and Adequacy			
1.	DCO describes the geographic distribution of all providers compared with the geographic distribution of members. The DCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	0.5	**Findings:** CDC provided member counts for different categories of time/distance, but it was unclear what type of provider (e.g., PCDs, EPDHs, and oral health specialists) to which the counts referred. Additionally, the DCO did not describe the geocoding application or software used to conduct the analysis, only referencing "state-of-the-art mapping software." **Recommendation for the Next Submission:** CDC should describe the geographic distribution by provider type compared with the geographic distribution of its members. The DCO should also precisely identify the geocoding application or software used to conduct the analysis.
2.	DCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0.5	**Findings:** CDC provided summary time and distance assessments of members, PCDs, and providers, but did not demonstrate that its analysis used the precise physical locations of members and providers when considering time and distance standards. Additionally, the DCO did not describe its methodologies for conducting the analysis, only referencing that it used "state-of-the-art mapping software." **Recommendation for the Next Submission:** CDC should provide a DSN analysis and methodology that uses the precise physical address-level locations of providers and members to determine geographic network adequacy.

Category Elements		Score	Findings/Recommendations
3.	DCO 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.	DCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	DCO discusses how the network ensures time and distance standards for member access to specialists. DCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	DCO describes the ratio of members to providers for PCDs, EPDHs, and Oral Health Specialists. DCO addresses ratios for pediatric, adult, and geriatric providers. The DCO should analyze these ratios and describe whether the DCO considers these ratios adequate.	0	**Findings:** CDC provided a count of each provider type but did not provide a methodology for analyzing the ratio of members to providers. The DCO provided the statement, "CDC feels these ratios are adequate as outlined in the capacity portion of the DSN report," but did not demonstrate how it arrived at that conclusion. CDC also did not describe what steps it would take if the ratios did not meet OHA standards. **Recommendation for the Next Submission:** CDC should provide an analysis with explanatory methodology examining the ratio of members to providers and specialists. The analysis should clearly demonstrate that the ratios meet OHA standards. CDC should also describe what steps it would take if the ratios did not meet OHA standards.
	Total Score	**4.0**	**Out of Possible 6.0**

Category Elements		Score	Findings/Recommendations
Description of Members			
7.	DCO describes its process for taking into account member characteristics when making provider assignments. • DCO provides analysis of the language and cultural needs of members. • DCO provides analysis of the needs of members with disabilities and members with special health care needs.	0.5	**Findings:** CDC stated that it "periodically runs reports of membership by language to better understand the membership breakdown" and that it promotes the member's right to choose a provider and assists members in selecting a "good fit" provider through its Member Services Team. However, the DCO did not provide the language analysis nor describe its process and/or procedure for conducting analysis of the cultural, disability, and special health care needs of its members, nor did it submit a cultural, language, disability, and special health care needs analysis to demonstrate the characteristics of its membership. **Recommendation for the Next Submission:** CDC should provide a cultural, language, disability, and special health care needs analysis to demonstrate the characteristics of its membership.
8.	DCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
9.	DCO analyzes patterns of underutilization and overutilization and the actions the DCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.5**	**Out of Possible 3.0**

Category Elements		Score	Findings/Recommendations
Additional Analysis of the DCO's Provider Network to Meet Member Needs			
10.	DCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis.	0.5	**Findings:** CDC described how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, but did not provide examples, scenarios, and/or supporting documentation to demonstrate the process. **Recommendation for the Next Submission:** CDC should provide examples, scenarios, and/or supporting documentation to demonstrate how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis.
11.	DCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
12.	DCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	1	Met
13.	DCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The DCO should address all levels within the organization, including leadership and provider network.	1	Met
14.	DCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	1	Met
	Total Score	**4.5**	**Out of Possible 5.0**

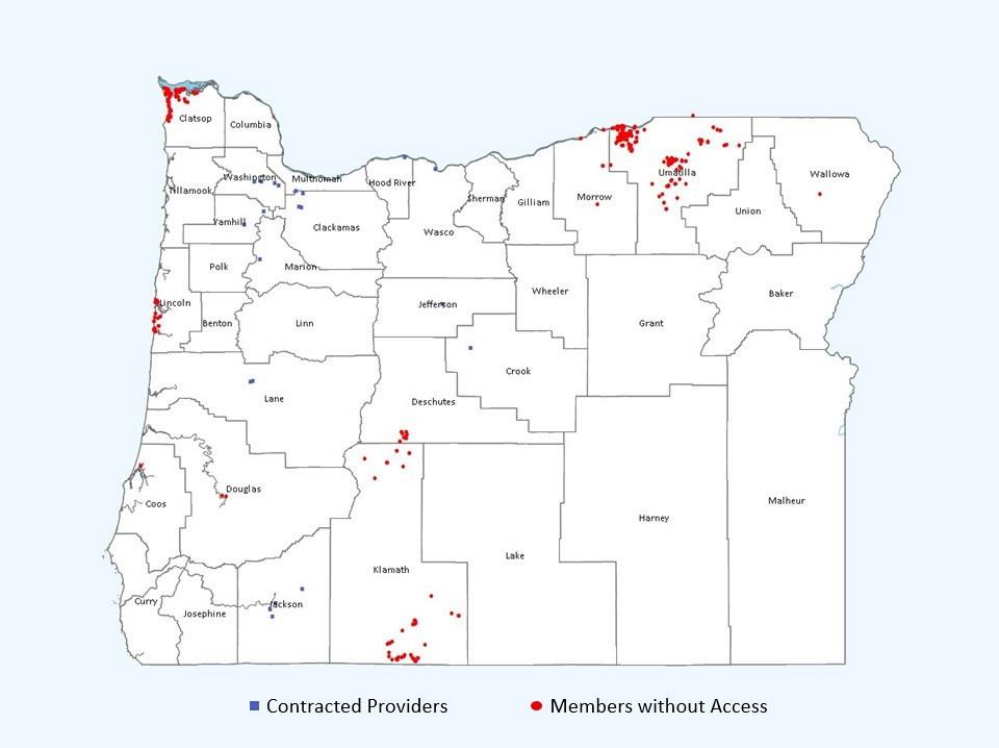
DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of CDC's network of oral health practitioners compared to its membership was sufficient to cover most of the DCO's service area (i.e., Benton, Clackamas, Clatsop, Columbia, Crook, Deschutes, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Umatilla, Wasco, Washington, and Yamhill 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.

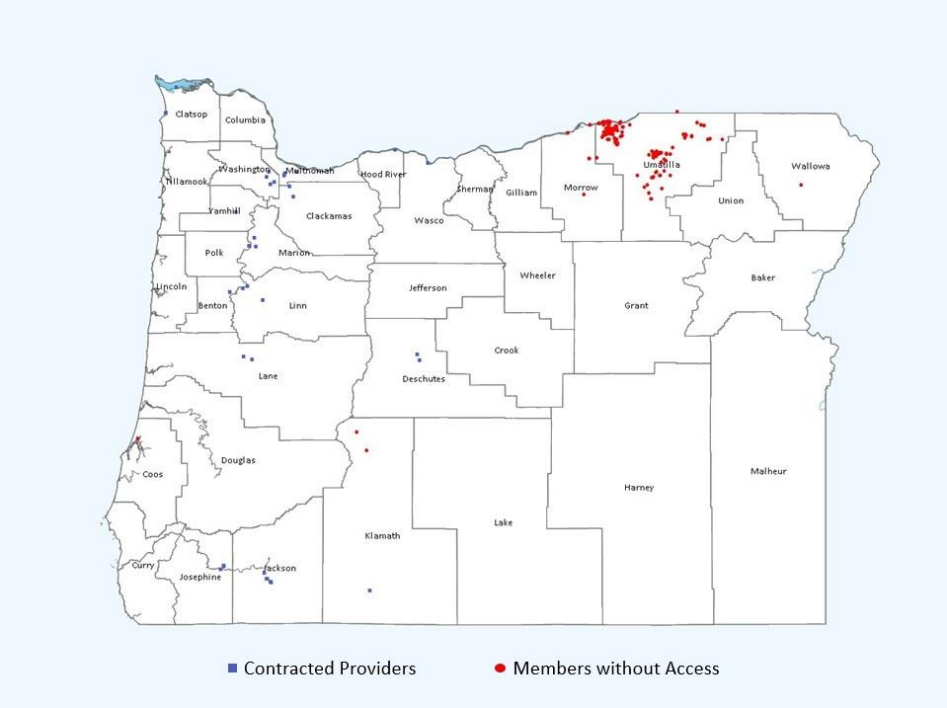
All of the ZIP Codes within CDC's service area represent a mix of urban and rural geographic classifications. As shown below in Figure B-1, the graphic representation illustrates members residing in rural areas without access to EPDHs within CDC's service area. HSAG's analysis identified 27 EPDHs at 21 locations. Of the 3,718 CDC members, 876 (23.6 percent) were without access within 60 miles/minutes in the DCO's service area.

Figure B-1—CDC—Rural Members Without Access to EPDHs



As shown below in Figure B-2, the graphic representation illustrates members residing in rural areas without access to EPDHs within CDC's service area. HSAG's analysis identified 43 Oral Health Specialists at 34 locations. Of the 3,718 CDC members, 577 (15.5 percent) were without access within 60 miles/minutes in the DCO's service area.

Figure B-2—CDC—Rural Members Without Access to Oral Health Specialists



Provider Network Quality and Count Results

CDC submitted a DSN Provider Capacity Report with all of the required data fields; however, the report did not include any data records identified as the Provider Category Description of Facility "03" or Business or Healthcare Services "04." The quality of the DCO's submitted oral health practitioner data records were fair with a few data quality issues. The following area of concern was observed in CDC's report:

- Of the oral health practitioner data records submitted, 100 percent of the providers had the Credentialing Date data field populated; however, only 97.5 percent of the values were valid.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 308 oral health 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 CDC's DSN Provider Capacity Report submission:

- Of the 308 total counted oral health practitioners, all of the data records were identified as contracted and in-network providers. The geographic distribution of in-network data records was 14 in Benton County, 14 in Clackamas County, six in Clatsop County, four in Columbia County, two in Crook County, 16 in Deschutes County, nine in Hood River County, 23 in Jackson County, two in Jefferson County, 18 in Josephine County, 11 in Klamath County, 31 in Lane County, four in Lincoln County,

17 in Linn, County 35 in Marion County, 47 in Multnomah County, eight in Polk County, two in Umatilla County, eight in Wasco County, 21 in Washington County, and 16 in Yamhill County.

- No Oral & Maxillofacial Pathologist, Prosthodontics, or Registered Dental Hygienist oral health practitioner data records were populated.
- No facility/business/service provider data records were populated.
- Of the seven total counted Endodontist oral health practitioner data records, none of the providers were identified as speaking a non-English language.
- After deduplication of Primary Care Dentist data records by NPI, 176 total contracted, in-network providers were identified. Of those data records, 134 (76.1 percent) were identified as Primary Care Dentist, Adult practitioners and 42 (23.9 percent) were identified as Primary Care Dentist, Pediatric practitioners.

Table B-4— Oral Health Practitioner and Facility/Business/Service Provider Counts for CDC

	All Providers		Contracted, In-Network Providers	
Services Category[1]	Number	Percent[2]	Number	Percent[2]
Oral Health Practitioners				
Primary Care Dentist, Adult	174	56.5%	174	56.5%
Primary Care Dentist, Pediatric	71	23.1%	71	23.1%
Expanded Practice Dental Hygienist	23	7.5%	23	7.5%
Orthodontist & Dentofacial Orthopedics	9	2.9%	9	2.9%
Oral & Maxillofacial Surgeon	11	3.6%	11	3.6%
Oral & Maxillofacial Pathologist	0	0.0%	0	0.0%
Periodontist	3	1.0%	3	1.0%
Endodontist	7	2.3%	7	2.3%
Denturist	10	3.2%	10	3.2%
Prosthodontics	0	0.0%	0	0.0%
Registered Dental Hygienist	0	0.0%	0	0.0%
Overall	**308**	**100.0%**	**308**	**100.0%**
Facility/Business/Service				
General Dental Clinic	0	—	0	—
Dental Clinic, Pediatric	0	—	0	—
Mobile Dental Clinic	0	—	0	—
Orthodontics & Dentofacial Orthopedics Clinic	0	—	0	—
Oral & Maxillofacial Surgery Clinic	0	—	0	—
Emergency Dental Services Clinic	0	—	0	—
Public/County Health Department	0	—	0	—

	All Providers		Contracted, In-Network Providers	
Services Category[1]	Number	Percent[2]	Number	Percent[2]
Certified or Qualified Health Care Interpreters	0	—	0	—
Federally Qualified Health Centers	0	—	0	—
Indian Health Service and Tribal Health Services	0	—	0	—
Rural Health Centers	0	—	0	—
School-based Health Centers	0	—	0	—
Overall	**0**	**—**	**0**	**—**

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

Family Dental Care, Inc.

DSN Provider Narrative Evaluation Results

Family Dental Care, Inc. (FDCi) contracts with OHA to provide oral health services to OHP members residing in Clackamas, Multnomah, and Washington counties. FDCi is the smallest of the five DCOs in terms of service area, membership, staff, and providers. FDCi is notably responsive and agile in meeting the needs of its individual members, describing and providing examples of addressing such things as low engagement rates, cultural competency training, and quickly addressing gaps in any services provided. FDCi earned a perfect score in terms of analysis of its network to meet member needs.

FDCi submitted a DSN Provider Narrative Report that spoke to almost all requirements but was often lacking in sufficient detail to conduct a full review. For instance, the DCO provided a unique visual "heat map" of its membership with regard to provider accessibility based on ZIP Code (rather than the required precise physical location) and described creating and using the maps twice a year to analyze geographic needs for its membership, stating that it met State standards without providing quantitative evidence of compliance. However, the analysis did not contain sufficient geocoding detail to understand and confirm precise relative geographic distributions and access times of members and providers. Additionally, the software type used to conduct the analysis and mapping was not identified beyond describing it as an "internally created hybrid process."

The DCO described a proactive process of assessment during member intake and "soft" PCD assignment, aided by its Member Services Team, but did not provide a formal analysis of its language, cultural, disability, and special health care needs of its membership. Additionally, FDCi neither described a process for ensuring continuity of care for outgoing members (stating that it helps with transitions on member request) nor a process for formal analysis of underutilization and overutilization patterns.

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

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

Category Elements		Score	Findings/Recommendations
Description of the Delivery Network and Adequacy			
1.	DCO describes the geographic distribution of all providers compared with the geographic distribution of members. The DCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	0.5	**Findings:** FDCi provided visual "heat maps" based on ZIP Codes and described creating and using the maps twice a year to analyze geographic needs for its membership. However, the analysis did not contain sufficient geocoding detail to understand precise relative geographic distributions of members and providers. Additionally, the software type was not described beyond "internally created hybrid process." **Recommendation for the Next Submission:** FDCi should provide an analysis that uses the precise physical addresses of members and providers to determine geographic distribution. The DCO should also describe the geocoding application or software used to conduct the analysis.
2.	DCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0.5	**Findings:** The ZIP Code-level heat maps provided by FDCi did not provide enough detail or context to determine the methodology or results of the analysis. The DCO stated that it meets the 90 percent standard but did not provide quantitative evidence to support the statement. The DCO was able to describe what steps it takes to improve access and ensure compliance. **Recommendation for the Next Submission:** FDCi should provide a DSN analysis demonstrating compliance with the time and distance standards.
3.	DCO 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

Category Elements		Score	Findings/Recommendations
4.	DCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	DCO discusses how the network ensures time and distance standards for member access to specialists. DCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	0.5	**Findings:** While FDCi was able to describe the steps it takes in cases in which gaps in care are identified, the DCO did not provide enough detail or context to determine the methodology or results of the analysis. The DCO stated that it meets the 90 percent standard but did not provide quantitative evidence to support the statement. **Recommendation for the Next Submission:** FDCi should provide a quantitative DSN analysis demonstrating compliance with the time and distance standards.
6.	DCO describes the ratio of members to providers for PCDs, EPDHs, and Oral Health Specialists. DCO addresses ratios for pediatric, adult, and geriatric providers. The DCO should analyze these ratios and describe whether the DCO considers these ratios adequate.	0.5	**Findings:** FDCi stated that it primarily monitors its specialist access through the grievance and appeal process. While the approach is responsive to expressed member needs and FDCi provided examples of appropriate responses to gaps in care, the DCO's overall approach did not demonstrate compliance with State access standards. The DCO stated that it meets the 90 percent standard but did not provide quantitative evidence to support the statement. **Recommendation for the Next Submission:** FDCi should provide a process that addresses and demonstrates quantitative compliance with State access standards.
	Total Score	**4.0**	**Out of Possible 6.0**

Category Elements		Score	Findings/Recommendations
Description of Members			
7.	DCO describes its process for taking into account member characteristics when making provider assignments. • DCO provides analysis of the language and cultural needs of members. • DCO provides analysis of the needs of members with disabilities and members with special health care needs.	0.5	**Findings:** While FDCi described a process of care coordination during intake and "soft" assignment, the DCO did not provide a formal analysis of the language, cultural, disability, and special health care needs of its members. **Recommendation for the Next Submission:** FDCi should provide a formal analysis of the language, cultural, disability, and special health care needs of its members.
8.	DCO describes how member needs for continuity of care and transition between levels of care are assessed.	0	**Findings:** FDCi stated that it assists with a member's transition between providers "upon a member's request." This did not describe a process for ensuring continuity of care for outgoing members. **Recommendation for the Next Submission:** FDCi should provide a process for how it ensures continuity of care for both incoming and outgoing members.
9.	DCO analyzes patterns of underutilization and overutilization and the actions the DCO has taken to address underutilization and overutilization.	0.5	**Findings:** FDCi provided one applicable example of how it addresses low engagement rates but did not describe its process and/or procedure for analyzing patterns of underutilization and overutilization. **Recommendation for the Next Submission:** FDCi should provide a process and/or procedure for analyzing pattems of underutilization and overutilization.
	Total Score	**1.0**	**Out of Possible 3.0**

Category Elements		Score	Findings/Recommendations
Additional Analysis of the DCO's Provider Network to Meet Member Needs			
10.	DCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis.	1	Met
11.	DCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
12.	DCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	1	Met
13.	DCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The DCO should address all levels within the organization, including leadership and provider network.	1	Met
14.	DCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of FDCi's network of oral health practitioners compared to its total membership was sufficient to cover most of the DCO's service area (i.e., Clackamas, Multnomah, and Washington 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 EPDH providers across all three counties.

All of the ZIP Codes within FDCi's service area represent a mix of urban and rural areas. As shown below in Figure B-3 and Figure B-4, the graphic representations illustrate pediatric members residing in rural areas without access to EPDH practitioners within FDCi's service area. HSAG's analysis identified no EPDH practitioners. All 2,926 (100 percent) members residing in urban classified areas were without access within 30 miles/minutes in the DCO's service area. Likewise, as a result of no EPDH practitioners, 138 (100 percent) members residing in rural classified areas were without access within 60 miles/minutes in the DCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of FDCi's service area.

Figure B-3—FDCi—Urban Members Without Access to EPDH Practitioners

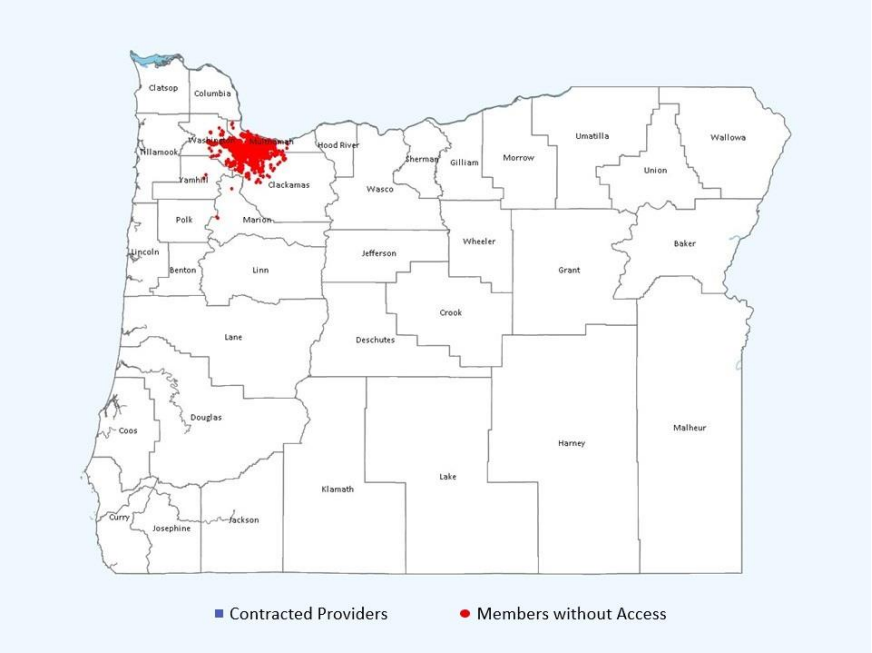
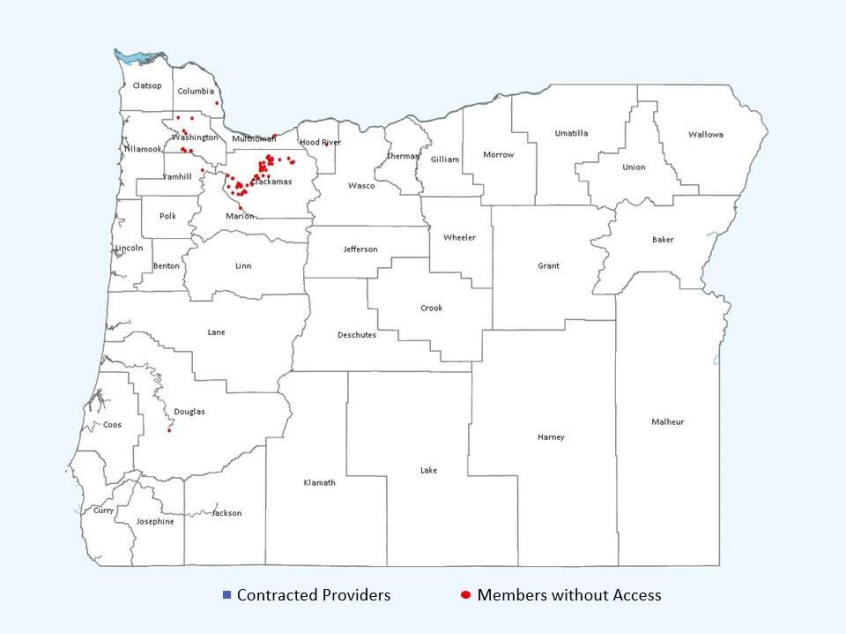


Figure B-4—FDCi—Rural Members Without Access to EPDH Practitioners



Provider Network Quality and Count Results

FDCi submitted a DSN Provider Capacity Report with all of the required data fields and accounted for both oral health practitioners and facility/business/service providers. Overall, the quality of the DCO's DSN Provider Capacity Report was fair with a several data quality issues. The following areas of concern were observed in FDCi's report:

- Of the oral health practitioner data records submitted, 100 percent had the Credentialing Date data field populated; however, only 93.6 percent of the values were valid.
- Of the facility/business/service provider data records submitted, 100 percent had the Facility NPI data field populated; however, only 94.7 percent of the values were valid.
- Of all the data records submitted, only 85.2 percent of the Status of Medicaid Contract data field values were populated.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 83 oral health practitioner and 16 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 FDCi's DSN Provider Capacity Report submission:

- Of the 83 total counted oral health practitioners, 81 data records were identified as contracted and in-network providers. The geographic distribution of in-network data records was 19 in Clackamas

County, 12 in Multnomah County, 49 in Washington County, and one remaining practitioner in the bordering county of Yamhill.

- Of the 16 total counted facility/business/service providers, no data records were identified as contracted and in-network providers.
- No total counted Expanded Practice Dental Hygienist, Orthodontist & Dentofacial Orthopedics, Oral & Maxillofacial Pathologist, Periodontist, Endodontist, or Prosthodontics oral health practitioner data records were populated.
- No total counted Mobile Dental Clinic, Orthodontics & Dentofacial Orthopedics Clinic, Emergency Dental Services Clinic, Public/County Health Department, Certified or Qualified Health Care Interpreters, Indian Health Service and Tribal Health Services, Rural Health Centers, or School-based Health Centers facility/business/service provider data records were populated.
- After deduplication of Primary Care Dentist data records by NPI, 45 contracted and in-network providers were identified. Of those data records, 40 (88.9 percent) were identified as Primary Care Dentist, Adult practitioners and five (11.1 percent) were identified as Primary Care Dentist, Pediatric practitioners.
- Of the five total counted contracted, in-network Primary Care Dentist, Pediatric data records, none of the providers were identified as speaking a non-English language.
- The one contracted, in-network Oral & Maxillofacial Surgeon data record was not a provider identified as speaking a non-English language.

Table B-6—Oral Health Practitioner and Facility/Business/Service Provider Counts for FDC

	All Providers		Contracted, In-Network Providers	
Services Category[1]	Number	Percent[2]	Number	Percent[2]
Oral Health Practitioners				
Primary Care Dentist, Adult	52	62.7%	51	63.0%
Primary Care Dentist, Pediatric	5	6.0%	5	6.2%
Expanded Practice Dental Hygienist	0	0.0%	0	0.0%
Orthodontist & Dentofacial Orthopedics	0	0.0%	0	0.0%
Oral & Maxillofacial Surgeon	1	1.2%	1	1.2%
Oral & Maxillofacial Pathologist	0	0.0%	0	0.0%
Periodontist	0	0.0%	0	0.0%
Endodontist	0	0.0%	0	0.0%
Denturist	1	1.2%	1	1.2%
Prosthodontics	0	0.0%	0	0.0%
Registered Dental Hygienist	24	28.9%	23	28.4%
Overall	**83**	**100.0%**	**81**	**100.0%**

Services Category[1]	All Providers		Contracted, In-Network Providers	
	Number	Percent[2]	Number	Percent[2]
Facility/Business/Service				
General Dental Clinic	7	43.8%	0	0.0%
Dental Clinic, Pediatric	3	18.8%	0	0.0%
Mobile Dental Clinic	0	0.0%	0	0.0%
Orthodontics & Dentofacial Orthopedics Clinic	0	0.0%	0	0.0%
Oral & Maxillofacial Surgery Clinic	1	6.3%	0	0.0%
Emergency Dental Services Clinic	0	0.0%	0	0.0%
Public/County Health Department	0	0.0%	0	0.0%
Certified or Qualified Health Care Interpreters	0	0.0%	0	0.0%
Federally Qualified Health Centers	5	31.3%	0	0.0%
Indian Health Service and Tribal Health Services	0	0.0%	0	0.0%
Rural Health Centers	0	0.0%	0	0.0%
School-based Health Centers	0	0.0%	0	0.0%
Overall	**16**	**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.

Managed Dental Care of Oregon, Inc.

DSN Provider Narrative Evaluation Results

Managed Dental Care of Oregon, Inc. (MDCO) contracts with OHA to provide oral health services to OHP members residing in Clackamas, Multnomah, and Washington counties.

MDCO submitted a DSN Provider Narrative Report with responses that largely met the requirements of both State access standards and DSN evaluation but left out some crucial details or did not explain some of its conclusions fully. MDCO's strengths include its Member Services Team, proactive Quality Improvement Committee, round-the-clock accessibility monitoring, use of teledentistry, funding support of pilot programs, and member touch-point education and outreach.

When describing its delivery network and network adequacy, MDCO provided member counts showing exemplary compliance with State access standards. However, the DCO did not precisely identify the geocoding application or software used to conduct the analysis. Similarly, while MDCO provided a count of its contracted PCDs and specialists, the DCO did not provide an analysis, methodology, or supporting documentation for determining that its ratio of members to PCDs and specialists was adequate—only a statement that it felt the ratios were adequate.

MDCO described processes for and gave examples of leveraging its experienced Member Services Team to promote members' right to choose a provider and assist members in selecting a provider of good fit. Behind this effort was a process of periodic analysis of MDCO's membership by language to better understand its membership demographics. However, no example analysis was provided, nor did the DCO provide an analysis of its cultural, disability, and special health care needs membership. Finally, the DCO did not provide examples, scenarios, and/or supporting documentation demonstrating how it incorporates member feedback into network adequacy decisions.

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

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

Category Elements		Score	Findings/Recommendations
Description of the Delivery Network and Adequacy			
1.	DCO describes the geographic distribution of all providers compared with the geographic distribution of members. The DCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	0.5	**Findings:** MDCO provided member counts for different categories of time/distance, but it was unclear what type of provider (e.g., PCDs) to which the counts referred. The member counts showed compliance with State access standards for time/distance. However, the DCO did not describe the geocoding application or software used to conduct the analysis, only referencing "state-of-the-art mapping software." **Recommendation for the Next Submission:** MDCO should provide a DSN analysis that uses the precise physical address-level locations of providers and members to determine geographic network adequacy. MDCO should also describe the geocoding application or software used to conduct the analysis.
2.	DCO discusses how the network ensures that the time and distance standards for member access to health care are met.	0.5	**Findings:** MDCO provided summary time and distance assessments of members, PCDs, and providers, but did not demonstrate that its analysis used the precise physical locations of members and providers when considering time and distance standards. Additionally, the DCO did not describe its methodologies for conducting the analysis, only referencing that it used "state-of-the-art mapping software." **Recommendation for the Next Submission:** MDCO should provide a DSN analysis and methodology that uses the precise physical address-level locations of providers and members to determine geographic network adequacy.

Category Elements		Score	Findings/Recommendations
3.	DCO 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.	DCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	DCO discusses how the network ensures time and distance standards for member access to specialists. DCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	DCO describes the ratio of members to providers for PCDs, EPDHs, and Oral Health Specialists. DCO addresses ratios for pediatric, adult, and geriatric providers. The DCO should analyze these ratios and describe whether the DCO considers these ratios adequate.	0	**Findings:** MDCO provided a count of each provider type but did not provide a methodology for calculating the ratio of members to providers. The DCO provided the statement, "MDCO feels these ratios are adequate as outlined in the capacity portion of the DSN report," but did not demonstrate how it arrived at that conclusion. MDCO also did not describe what steps it would take if the ratios did not meet OHA standards. **Recommendation for the Next Submission:** MDCO should provide an analysis and methodology for calculating the ratio of members to providers including periodontists. The analysis should clearly demonstrate that the ratios meet OHA standards. MDCO should also describe what steps it would take if the ratios did not meet OHA standards.
	Total Score	**4.0**	**Out of Possible 6.0**

Category Elements		Score	Findings/Recommendations
Description of Members			
7.	DCO describes its process for taking into account member characteristics when making provider assignments. • DCO provides analysis of the language and cultural needs of members. • DCO provides analysis of the needs of members with disabilities and members with special health care needs.	0.5	**Findings:** MDCO stated that it "periodically runs reports of membership by language to better understand the membership breakdown" and that it promotes the member's right to choose a provider and assists members in selecting a "good fit" provider through its Member Services Team. However, the DCO did not provide the language analysis nor describe its process and/or procedure for conducting analysis of the cultural, disability, and special health care needs of its members, nor did it submit a cultural, language, disability, and special health care needs analysis to demonstrate the characteristics of its membership. **Recommendation for the Next Submission:** MDCO should provide a cultural, language, disability, and special health care needs analysis to demonstrate the characteristics of its membership.
8.	DCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
9.	DCO analyzes patterns of underutilization and overutilization and the actions the DCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.5**	**Out of Possible 3.0**

Category Elements		Score	Findings/Recommendations
Additional Analysis of the DCO's Provider Network to Meet Member Needs			
10.	DCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis.	0.5	**Findings:** MDCO described how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis, but did not provide examples, scenarios, and/or supporting documentation to demonstrate the process. **Recommendation for the Next Submission:** MDCO should provide examples, scenarios, and/or supporting documentation to demonstrate how it incorporates member feedback into network adequacy decisions, including complaint and grievance analysis.
11.	DCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
12.	DCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	1	Met
13.	DCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The DCO should address all levels within the organization, including leadership and provider network.	1	Met
14.	DCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	1	Met
	Total Score	**4.5**	**Out of Possible 5.0**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of MDCO's network of oral health practitioners compared to its membership was sufficient to cover the DCO's service area (i.e., Clackamas, Multnomah, and Washington 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. All of the ZIP Codes within MDCO's service area represent a mix of urban and rural geographic classifications. No deficiencies were assessed, validating that 90 percent of MDCO's adult and pediatric members had access to all required provider service categories.

Provider Network Quality and Count Results

MDCO submitted a DSN Provider Capacity Report with all of the required data fields; however, the report did not include any data records identified as the Provider Category Description of Facility "03" or Business or Healthcare Services "04." The quality of the DCO's submitted oral health practitioner data records were good with minimal data quality issues.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 81 oral health practitioner and no 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 MDCO's DSN Provider Capacity Report submission:

- Of the 81 total counted oral health practitioners, all of the data records were identified as contracted and in-network providers. The geographic distribution of the data records was 14 in Clackamas County, 45 in Multnomah County, 21 in Washington County, and one remaining practitioner in the bordering county of Lane.
- No facility/business/service provider data records were populated.
- After deduplication of Primary Care Dentist data records by NPI, 58 total contracted, in-network providers were identified. Of those data records, 37 (63.8 percent) were identified as Primary Care Dentist, Adult practitioners and 21 (36.2 percent) were identified as Primary Care Dentist, Pediatric practitioners.
- The one contracted, in-network Endodontist provider data record was not a provider identified as speaking a non-English language.

Table B-8—Oral Health Practitioner and Facility/Business/Service Provider Counts for MDCO

	All Providers		Contracted, In-Network Providers	
Services Category[1]	Number	Percent[2]	Number	Percent[2]
Oral Health Practitioners				
Primary Care Dentist, Adult	41	50.6%	41	50.6%
Primary Care Dentist, Pediatric	22	27.2%	22	27.2%
Expanded Practice Dental Hygienist	7	8.6%	7	8.6%
Orthodontist & Dentofacial Orthopedics	0	0.0%	0	0.0%
Oral & Maxillofacial Surgeon	4	4.9%	4	4.9%
Oral & Maxillofacial Pathologist	0	0.0%	0	0.0%
Periodontist	3	3.7%	3	3.7%
Endodontist	1	1.2%	1	1.2%
Denturist	3	3.7%	3	3.7%
Prosthodontics	0	0.0%	0	0.0%
Registered Dental Hygienist	0	0.0%	0	0.0%
Overall	**81**	**100.0%**	**81**	**100.0%**
Facility/Business/Service				
General Dental Clinic	0	—	0	—
Dental Clinic, Pediatric	0	—	0	—
Mobile Dental Clinic	0	—	0	—
Orthodontics & Dentofacial Orthopedics Clinic	0	—	0	—
Oral & Maxillofacial Surgery Clinic	0	—	0	—
Emergency Dental Services Clinic	0	—	0	—
Public/County Health Department	0	—	0	—
Certified or Qualified Health Care Interpreters	0	—	0	—
Federally Qualified Health Centers	0	—	0	—
Indian Health Service and Tribal Health Services	0	—	0	—
Rural Health Centers	0	—	0	—
School-based Health Centers	0	—	0	—
Overall	**0**	**—**	**0**	**—**

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

ODS Community Dental

DSN Provider Narrative Evaluation Results

ODS Community Dental (ODS) contracts with OHA to provide oral health services to OHP members residing in Baker, Benton, Clackamas, Clatsop, Columbia, Crook (closed to new members), Deschutes, Hood River, Jackson, Jefferson (closed to new members), Josephine, Lane, Linn, Malheur, Marion, Multnomah, Polk, Tillamook, Wallowa, Wasco, Washington, and Yamhill counties.

ODS provided an exceptional DSN Provider Narrative Report including a sophisticated and comprehensive DSN analysis as supporting documentation. ODS provided thorough explanations of its policies, methodologies, and multiple examples of regular and thorough monitoring of its provider network, member access ratio analysis, specialist access, care coordination, and leveraging of its robust in-house electronic and IT resources.

The only finding for ODS was in regard to taking member characteristics into account when making provider assignments, both at the level of population analysis and at individual member assignments. While the DCO described its provision of interpretive services and the hiring of an in-house Latino specialist for culturally responsive services, no analysis of its membership was provided, so the rationale for this focus could not be assessed. ODS did not describe how it considers member characteristics when assigning members to appropriate providers, stating that it assigns members by ZIP Code and provides "a search tool" for members.

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

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

Category Elements		Score	Findings/Recommendations
Description of the Delivery Network and Adequacy			
1.	DCO describes the geographic distribution of all providers compared with the geographic distribution of members. The DCO may use geocoding and should include analysis of how members can access services, with supporting documentation, as needed.	1	Met
2.	DCO discusses how the network ensures that the time and distance standards for member access to health care are met.	1	Met
3.	DCO 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.	DCO analyzes wait times for appointments with providers, including specialists.	1	Met
5.	DCO discusses how the network ensures time and distance standards for member access to specialists. DCO describes efforts to address local service gaps through telemedicine or video conferencing for specialist consultations.	1	Met
6.	DCO describes the ratio of members to providers for PCDs, EPDHs, and Oral Health Specialists. DCO addresses ratios for pediatric, adult, and geriatric providers. The DCO should analyze these ratios and describe whether the DCO considers these ratios adequate.	1	Met
	Total Score	**6.0**	**Out of Possible 6.0**
Description of Members			
7.	DCO describes its process for taking into account member characteristics when making provider assignments. • DCO provides analysis of the language and cultural needs of members. • DCO provides analysis of the needs of members with disabilities and members with special health care needs.	0	**Findings:** ODS described its provision of interpretive services and the hiring of an in-house Latino specialist for culturally responsive services. However, no analysis of its membership was provided. The DCO described assigning members by ZIP Code and providing an online provider search tool for members.

Category Elements		Score	Findings/Recommendations
			Recommendation for the Next Submission: ODS should provide an analysis of the cultural, language, disability, and special health care needs of its membership. ODS should also describe how it takes member characteristics into account when assigning members to the appropriate provider.
8.	DCO describes how member needs for continuity of care and transition between levels of care are assessed.	1	Met
9.	DCO analyzes patterns of underutilization and overutilization and the actions the DCO has taken to address underutilization and overutilization.	1	Met
	Total Score	**2.0**	**Out of Possible 3.0**
Additional Analysis of the DCO's Provider Network to Meet Member Needs			
10.	DCO describes how it incorporates enrollee feedback into network adequacy decisions, including complaint and grievance analysis.	1	Met
11.	DCO describes how it uses technology to deliver team-based care and other innovations.	1	Met
12.	DCO describes procedures to ensure that enrollees with specific health care needs receive follow-up and training in self-care and other interventions, as appropriate, that enrollees may take to promote their own health.	1	Met
13.	DCO describes how it demonstrates its commitment to culturally and linguistically appropriate services (including information on access to certified health care interpreters). The DCO should address all levels within the organization, including leadership and provider network.	1	Met
14.	DCO describes how it uses its electronic health record to coordinate health care, including preventive health care, for all enrollees across the continuum of care.	1	Met
	Total Score	**5.0**	**Out of Possible 5.0**

DSN Provider Capacity Analysis Results

Geographic Distribution Results

In general, the geographic distribution of ODS' network of oral health practitioners compared to its total membership was sufficient to cover most of the DCO's service area (i.e., Baker, Benton, Clackamas, Clatsop, Columbia, Crook (closed to new members), Deschutes, Hood River, Jackson, Jefferson (closed to new members), Josephine, Lane, Linn, Malheur, Marion, Multnomah, Polk, Tillamook, Wallowa, Wasco, Washington, and Yamhill 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 EPDH providers across all three counties.

All of the ZIP Codes within ODS' service area represent a mix of urban and rural areas. As shown below in Figure B-5 and Figure B-6, the graphic representations illustrate pediatric members residing in rural areas without access to EPDH practitioners within ODS' service area. HSAG's analysis identified no EPDH practitioners. All 9,624 (100 percent) members were without access within 30 miles/minutes in the DCO's service area. Likewise, as a result of no EPDH practitioners, 2,608 (100 percent) members residing in rural classified areas were without access within 60 miles/minutes in the DCO's service area. Please take note that the OHA-provided beneficiary data included members residing in counties outside of ODS' service area.

Figure B-5—ODS—Urban Members Without Access to EPDH Practitioners

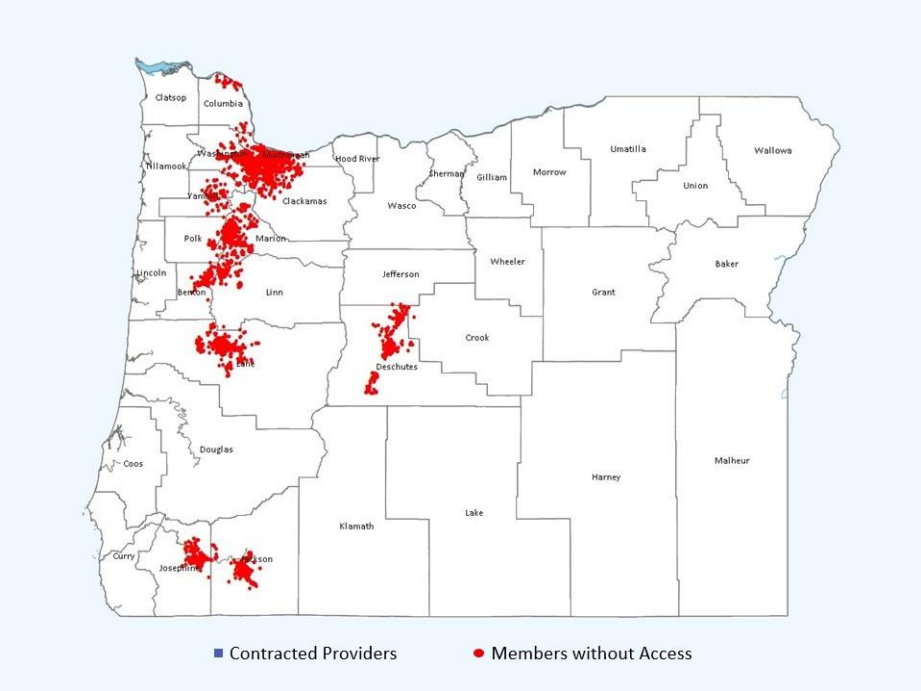
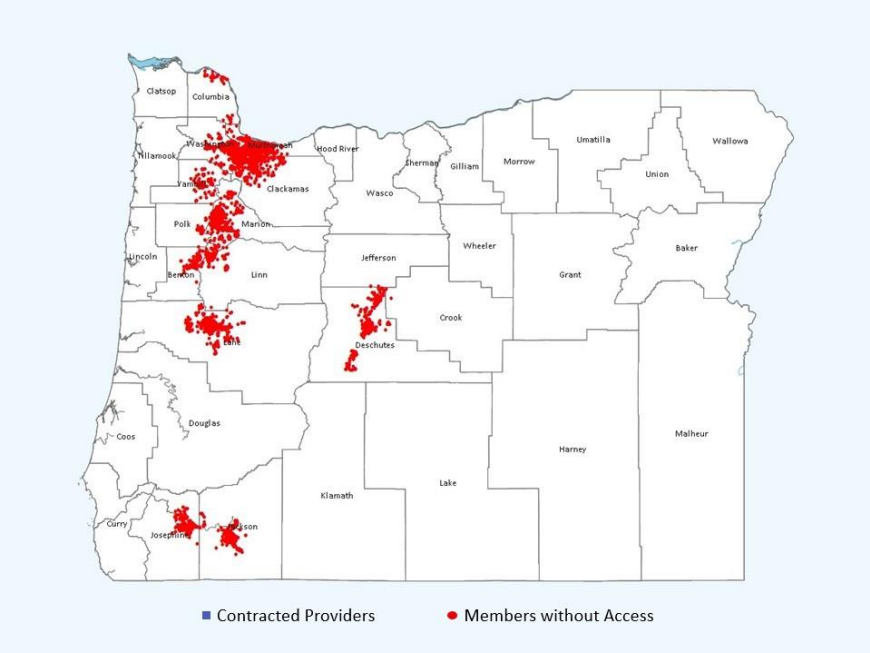


Figure B-6—ODS—Rural Members Without Access to EPDH Practitioners



Provider Network Quality and Count Results

ODS submitted a DSN Provider Capacity Report with all of the required data fields; however, the report did not include any data records identified as the Provider Category Description of Facility "03" or Business or Healthcare Services "04." The quality of the DCO's submitted oral health practitioner data records were fair with a few data quality issues. The following area of concern was observed in ODS' report:

- Of the records submitted, 100 percent of the Provider Service Category data field had values populated; however, 95.9 percent were valid values. "DSPP/DSPA," an invalid format and value, were populated in all data records.

After processing, cleaning, and deduplication, HSAG's analysis resulted in a total count of 1,888 oral health practitioner and no 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 ODS' DSN Provider Capacity Report submission:

- Of the 1,888 total counted oral health practitioners, all of the data records were identified as contracted, in-network providers. The geographic distribution of the data records within ODS' service area were 15 in Baker County, 41 in Benton County, 239 in Clackamas County, 24 in Clatsop County, 17 in Columbia County, seven in Crook County (closed to new members), 64 in Deschutes County, 28 in Hood River County, 80 in Jackson County, four in Jefferson County

(closed to new members), 50 in Josephine County, 128 in Lane County, 40 in Linn County, 31 in Malheur County, 165 in Marion County, 410 in Multnomah County, 39 in Polk County, 15 in Tillamook County, nine in Wallowa County, 31 in Wasco County, 352 in Washington County, and 42 in Yamhill County; totaling 1,831 practitioners. Fifty-seven practitioners were identified as in-network oral health practitioners, with a geographic distribution of one in Curry County, 12 in Douglas County, two in Grant County, nine in Klamath County, 11 in Lincoln County, seven in Umatilla County, 11 in Union County, and four in Wheeler County, all counties outside of ODS' service area.

- No Expanded Practice Dental Hygienist, Oral & Maxillofacial Pathologist, or Registered Dental Hygienist oral health practitioner data records were populated.
- No facility/business/service provider data records were populated.
- After deduplication of Primary Care Dentist data records by NPI, 1,317 total contracted, in-network providers were identified. Of those data records, 619 (47.0 percent) were identified as Primary Care Dentist, Adult practitioners and 698 (53.0 percent) were identified as Primary Care Dentist, Pediatric practitioners.

Table B-10—Oral Health Practitioner and Facility/Business/Service Provider Counts for ODS

	All Providers		Contracted, In-Network Providers	
Services Category[1]	Number	Percent[2]	Number	Percent[2]
Oral Health Practitioners				
Primary Care Dentist, Adult	795	42.1%	795	42.1%
Primary Care Dentist, Pediatric	921	48.8%	921	48.8%
Expanded Practice Dental Hygienist	0	0.0%	0	0.0%
Orthodontist & Dentofacial Orthopedics	27	1.4%	27	1.4%
Oral & Maxillofacial Surgeon	64	3.4%	64	3.4%
Oral & Maxillofacial Pathologist	0	0.0%	0	0.0%
Periodontist	13	0.7%	13	0.7%
Endodontist	20	1.1%	20	1.1%
Denturist	47	2.5%	47	2.5%
Prosthodontics	1	0.1%	1	0.1%
Registered Dental Hygienist	0	0.0%	0	0.0%
Overall	**1,888**	**100.0%**	**1,888**	**100.0%**
Facility/Business/Service				
General Dental Clinic	0	—	0	—
Dental Clinic, Pediatric	0	—	0	—
Mobile Dental Clinic	0	—	0	—
Orthodontics & Dentofacial Orthopedics Clinic	0	—	0	—

	All Providers		Contracted, In-Network Providers	
Services Category[1]	Number	Percent[2]	Number	Percent[2]
Oral & Maxillofacial Surgery Clinic	0	—	0	—
Emergency Dental Services Clinic	0	—	0	—
Public/County Health Department	0	—	0	—
Certified or Qualified Health Care Interpreters	0	—	0	—
Federally Qualified Health Centers	0	—	0	—
Indian Health Service and Tribal Health Services	0	—	0	—
Rural Health Centers	0	—	0	—
School-based Health Centers	0	—	0	—
Overall	**0**	**—**	**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. DCO Plan Names

Acronym	DCO Plan Name
ADS	Advantage Dental Services, LLC
CDC	Capitol Dental Care, Inc.
FDCi	Family Dental Care, Inc.
MDCO	Managed Dental Care of Oregon, Inc.
ODS	ODS Community Dental