1. **Delivery System Network (DSN) Reports**

Contractor shall demonstrate its DSN Provider Capacity by submitting a DSN Provider Narrative Report and a DSN Provider Capacity Report to OHA as specified in this Section 1 no later than July 1st of every year. Subsequently, Contractor shall update these reports any time there has been a Material Change in Contractor’s operations that would affect adequate capacity and services, and upon OHA request.

a. **DSN Provider Narrative Report**

   (1) Pursuant to 42 CFR 438.206 “Availability of Services” and 42 CFR 438.207 “Assurances of Adequate Capacity and Services,” Contractor shall ensure to OHA, with supporting documentation, that all Covered Services are available and accessible to Members and that the Contractor demonstrates adequate Provider capacity.

   (2) Contractor shall provide the following information of how it requires and monitors adequate Provider capacity. If any of the activities are subcontracted, Contractor shall describe how it provides oversight and monitoring of the activities as well. Contractor may elect to contract for or to delegate responsibility for the reporting and monitoring of adequate Provider capacity; however, Contractor shall be responsible for the following activities, including oversight of the following processes, regardless of whether the activities are provided directly, contracted or delegated.

   (a)  

      (i) How does Contractor maintain a DSN of appropriate Providers to sufficiently provide adequate access to all Covered Services including Special Health Care Needs?

      (ii) How does Contractor monitor the DSN of appropriate Providers to sufficiently provide adequate access to all services covered under this Contract including Special Health Care Needs?

   (b) If the DSN is unable to provide necessary Covered Services, to a particular Member, how does Contractor provide adequate and timely services out of its DSN for a
Member, for as long as the Contractor is unable to provide them within its DSN?

(c) How does Contractor require Providers to meet OHA standards for timely access to routine, urgent and emergent care and services, taking into account the urgency of the need for services?

(ii) How does Contractor monitor compliance by Providers of timely access to care and services?

(iii) How does Contractor monitor availability of services when Medically Appropriate routine, urgent and emergent services?

(d) What Corrective Actions has Contractor taken if there was a failure to comply with any provision or timeliness of services during the prior year? If, any, what is the current status of the Corrective Action and compliance?

(e) In the current year, what is Contractor doing to provide delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds?

(f) What does Contractor do to monitor subcontracted activities related to Provider capacity? Be specific to each activity subcontracted.

b. DSN Provider Capacity Report

Contractor shall describe its DSN capacity by submitting a DSN Provider Capacity Report on July 1st of every year, with its DNS Provider Narrative as described above, for the following categories of services or types of service providers. All Contractor’s DSN service providers, whether employed by or under subcontract with Contractor or paid fee-for-service, must have agreed with Contractor to provide the described services or items to Medicaid and Fully Dual Eligible Members. Contractor shall base its DSN upon its community health assessment (if available), community health improvement plan (if available), and Transformation Plan for delivery of integrated and coordinated health, mental health, and Substance Use Disorders treatment services and supports (and Dental Services if Dental Services are included in this Contract (see “Contract Document” Part II, Section C).
Contractor shall include in its DSN Provider Capacity Report the data elements in Subsection (2)(b) below about each Provider or facility Subsection (2)(a) below, using Excel format; however, certain categories of providers may be described in narrative form as described in Subsection (3) below.

(a) Providers should be grouped by category. For example, all Substance Use Disorders treatment Providers should be listed together; all Ambulance and Emergency Medical Transportation Providers should be listed together.

(b) For patient centered primary care homes, a listing of the Providers who participate in that PCPCH should be listed together; it is not necessary to duplicate those same Providers in the other categories. Information should include the certification Tier and number of Members covered by the Provider.

(c) For Mental Health Crisis Services, Contractor shall list separately the number of Crisis Hot Lines, Crisis Walk in Centers, Mobile Crisis Teams, Crisis Respite Centers and Short-term Crisis Stabilization Units.
(2) Required Data Elements:

(a) Practitioners and Facilities:

(i) Name of Practitioner or Facility
(ii) Type of Practitioner or Facility
(iii) Address
(iv) Telephone number
(v) NPI number
(vi) Non-English language spoken

(b) Category of Service

(i) Acute inpatient hospital psychiatric care
(ii) Ambulance and Emergency Medical Transportation
(iii) Certified or Qualified Health Care Interpreters
(iv) Certified Traditional Health Workers
(v) Community prevention services
(vi) Dental Services Providers
(vii) Federally qualified health centers
(viii) Health education, health promotion, health literacy
(ix) Home health
(x) Hospice
(xi) Hospital
(xii) Imaging
(xiii) Indian Health Service and tribal health services
(xiv) Mental health Providers
(xv) Mental Health Crisis Services
(xvi) Non-Emergent Medical Transportation
(xvii) Oral health Providers
(xviii) Palliative care
(xix) Patient Centered Primary Care Homes
(xx) Pharmacies and durable medical Providers
(xxi) Post-hospital skilled nursing facility
(xxii) Primary Care Providers
(xxiii) Rural health centers
(xxiv) School-based health centers
(xxv) Specialty practitioners
(xxvi) Substance Use Disorders Providers
(xxvii) Traditional Health Workers
(xxviii) Urgent care center
(xxix) Others not listed but included in the Contractor’s integrated and coordinated service delivery network.
Narrative Information for other Provider categories: The categories of Certified Traditional Health Workers and Traditional Health Workers may not be suitable for the foregoing format. Contractor may describe in narrative form how its DSN makes provision of these services, their training and supervision, and their integration into the Contractor’s integrated and coordinated care delivery system.

c. **Cooperative Agreements with Publicly Funded Programs Report:**

To implement and formalize coordination and ensure relationships exist between Contractor and publicly funded health care and service programs, Contractor shall complete the following table and submit it to the OHA Contract Administration Unit by July 1st of every year, and provide additional information upon OHA request.

<table>
<thead>
<tr>
<th>Name of publicly funded program</th>
<th>Type of public program [(e.g., county mental health dept.)]</th>
<th>County in which program provides services</th>
<th>Does Contractor have a Memorandum of Understanding? [Description of the services provided in relation to Contractor’s services]</th>
<th>What has been the involvement of the public program in Contractor’s operations (on the board, on the Community Advisory Council, on Quality Assurance Committee, specify if subcontract, etc.)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Mental Health Authority</td>
<td>(Type B AAA) Community Mental Health Programs State APD district offices Local public health authority</td>
<td>County in which program provides services</td>
<td>Does Contractor have a Memorandum of Understanding? [Description of the services provided in relation to Contractor’s services]</td>
<td>What has been the involvement of the public program in Contractor’s operations (on the board, on the Community Advisory Council, on Quality Assurance Committee, specify if subcontract, etc.)?</td>
</tr>
</tbody>
</table>

d. **Cooperative Agreements with Community Social and Support Service and Long Term Care Report:**

To implement and formalize coordination and ensure relationships exist between Contractor and the following entities, Contractor shall provide the following information in a brief narrative report or table and submit to the
OHA Contract Administration Unit by July 1\textsuperscript{st} of every year, and provide additional information upon OHA request.

(1) Referral and cooperative arrangements with culturally diverse social and support services organizations, required to be established by Exhibit B Part 4 (5)(c).

(2) Cooperative arrangements and agreements to provide for medications with residential, nursing facilities, foster care and group homes, required by Exhibit B Part 4 (5)(e).

(3) Cooperative arrangements and agreements with DHS Child Welfare offices to assure timely assessments for Member children placed under Child Welfare custody, as required by Exhibit B, Part 2 (6)(k)(1)(b).
2. Hospital Network Adequacy

a. Contractor shall submit to the OHA Contract Administration Unit by March 31, of every year the Hospital Adequacy Report available on the Contract Reports Web Site. This Hospital Adequacy Report is an annual report of admissions and paid amounts from July 1 of every year to June 30 of every year, that details Hospital admissions at Contracted Hospitals and Hospital admissions at Non-Contracted Hospitals. The Hospital Adequacy Report will also include the Contractor’s total outpatient costs at Contracted Hospitals and the Contractor’s total outpatient costs at Non-Contracted Hospitals. OHA will review and analyze non-contracted claims by Contractor annually to determine if all Hospital services are adequately represented.

b. Contractor and Hospitals are expected to contract for an adequate Hospital network for a full range of services reasonably expected to meet the needs of the Contractor’s number and location of Members.

Definitions:

Contracted Hospital - in this Exhibit G means a Hospital that is a Subcontractor.

Non-Contracted Hospital – in this Exhibit G means a Hospital that is not a Subcontractor.

The following benchmarks will be monitored and evaluated to assess the adequacy of a Hospital network:

a. A minimum of 90% of Contractor’s total inpatient admissions (excluding all outpatient services) shall be provided in Hospitals under contract with the Contractor.

b. A minimum of 90% of Contractor’s total dollars paid for all outpatient services (excluding amounts paid for inpatient admissions) shall be provided in Hospitals under contract with the Contractor.

In those instances where the percentage of Non-Contracted Hospital services are below the benchmarks or the OHA review of the Contractor’s annual report of Hospital admissions by DRG indicates Contractor’s Hospital network is not adequate, OHA shall determine if the Contractor and Hospital(s) have both made a good faith effort to contract with each other.

The determination of good faith shall consider the following:

a. The amount of time the Contractor has been actively trying to negotiate a contractual arrangement with the Hospital(s) for the services involved;
b. The payment rates and methodology the Contractor has offered to the Hospital(s);

c. The payment rates and methodology the Hospital has offered to the Contractor;

d. Other Hospital cost associated with non-financial contractual terms the Contractor has proposed including prior-authorization and other utilization management policies and practices;
e. The Contractor’s track record with respect to claims payment timeliness, overturned claims, denials, and Hospital complaints;

f. The Contractor’s solvency status; and

g. The Hospital(s)’ reasons for not contracting with the Contractor.

h. If OHA determines that the Contractor has made a good faith effort to contract with the Hospital, OHA shall modify the benchmark calculation, if necessary, for the Contractor to exclude the Hospital so the Contractor is not penalized for a Hospital’s failure to contract in good faith with the Contractor.

i. If OHA determines that the Contractor did not make a good faith effort, to negotiate and enter into reasonable contracts, OHA may invoke the following remedies (until such time that the Contractor achieves the benchmarks or provides documentation to OHA that it has an adequate Hospital panel):

   (1) Monthly reporting;

   (2) Partial withholding of CCO Payments (to be returned retroactively to the Contractor upon achieving compliance or termination/non-renewal of the contract); and finally,

   (3) Termination or non-renewal of this Contract.