State of New Hampshire Department of Health and Human Services

State Fiscal Year 2024 Network Adequacy Validation Report

November 2024

—Final Copy—

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgements and Conflict of Interest Statement

The preparation of this report was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

Health Services Advisory Group, Inc. confirms that no one conducting the state fiscal year (SFY) 2024 network adequacy validation (NAV) has a conflict of interest with the following Managed Care Entities (MCEs): **AmeriHealth Caritas New Hampshire** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), **WellSense Health Plan** (**WS**), and Delta Dental Plan of New Hampshire, Inc. DBA **NorthEast Delta Dental (NEDD)** and the plan administrator, **DentaQuest** (**DQ**).

1. Executive Summary

Introduction

The New Hampshire Department of Health and Human Services (DHHS) is responsible for the ongoing monitoring and oversight of its contracted Medicaid managed care entities (MCEs) that deliver physical health, behavioral health, and pharmacy services to members under the Medicaid Care Management (MCM) and dental services under the Dental Medicaid Care Management (DMCM) programs. Title 42 of the Code of Federal Regulations (42 CFR) §438.350(a) requires that states which contract with managed care organizations (MCOs) set quantifiable standards for measuring adequate provider networks and have a qualified external quality review organization (EQRO) perform an annual external quality review (EQR) that validates network adequacy according to the Centers for Medicare & Medicaid Services (CMS) EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).[1]

DHHS' EQRO, Health Services Advisory Group, Inc. (HSAG), conducted the SFY 2024 NAV, assessing the accuracy of the state-defined network adequacy indicators that the MCEs reported. HSAG evaluated the collection, reliability, and validity of provider and network adequacy data, and the methodologies, systems, and processes the MCEs used to calculate and report indicators of network adequacy. HSAG used a CMS-suggested methodology to determine an overall validation rating for each indicator which reflects HSAG's overall confidence that each MCE used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators set by DHHS.

HSAG assessed the MCEs listed below during SFY 2024:

MCOs

- **AmeriHealth Caritas New Hampshire, Inc.** (**ACNH**)
- **New Hampshire Healthy Families** (**NHHF**)
- **WellSense Health Plan** (**WS**)

DO

- **Delta Dental Plan of New Hampshire, Inc**. DBA **NorthEast Delta Dental** (**NEDD**) and the plan administrator, **DentaQuest** (**DQ**)

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Sept 16, 2024.

Methodology

HSAG collaborated with DHHS to define the scope of the validation of quantitative network adequacy standards, which included the identification and definition of the network adequacy standards, provider types, and indicators for validation, based on the relevant contract standards and state-required reporting templates.

HSAG conducted the following activities during SFY 2024:

- **Information systems capabilities assessment (ISCA)**: In accordance with CMS Protocol 4, HSAG conducted a desk review of materials that the MCEs submitted, supplemented with live virtual review sessions demonstrating the information systems, data processing procedures, and underlying methodology that the MCEs utilized to support their network adequacy indicator reporting.
- **Time and distance analysis**: New Hampshire requires MCEs to meet geographic access standards by providing access to a minimum number of network providers within a minimum driving distance or driving time from members' residences.[2] These standards apply to a broad range of provider categories, including but not limited to primary care providers (PCPs), mental health providers, substance use disorder (SUD) service providers, hospitals and other facilities, and several types of physician specialists as shown in Appendix A. For each MCE, HSAG calculated the percentage of members able to access care within the time or distance requirements defined in the DHHS MCM Services Contract and the required reporting template.
- **Network capacity analysis**: New Hampshire requires MCOs to meet network capacity standards for four specific types of SUD service providers. DHHS limited the scope of this year's work to two of them: Opioid treatment providers (OTPs) and residential SUD treatment programs. For each of these provider categories, DHHS requires the MCOs to contract with a minimum percentage of the total providers licensed and practicing in the State. HSAG assessed whether each MCO met these standards by comparing the MCOs' provider data to the list of licensed and practicing providers in the DHHS report template.

Appendix B contains further details on the methodology.

Key Findings

ISCA findings: All four MCEs cooperated fully with the ISCA process and provided HSAG with the requested access to their information systems. Based on the validation ratings across all types of standards and all individual indicators that HSAG examined, HSAG has high confidence in the MCEs' data systems, methodologies, and the accuracy and reliability of their reported results. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data

[2] Such standards are generally referred to as "time and distance" standards, although in the case of New Hampshire, an MCE need only meet either the time *or* distance element. As DHHS does in its template, HSAG calculated both time and distance and counted and indicator met if one or both were within the standard.

systems for any of the MCEs, although HSAG did identify some opportunities for improvement and discusses them more fully in the appropriate MCE's individual results.

Time and distance analysis: HSAG's time and distance analysis produced results consistent with the results that MCEs reported in their data submissions to DHHS. HSAG presents the results for all three MCOs in Appendix C. As required by DHHS, all of the MCEs met either the time or distance standard for most provider categories. **ACNH** met the standards for 95.0 percent of the provider categories, **NHHF** met the standards for 98.4 percent of the provider categories, **WS** met the standards for 73.8 percent of the provider categories, and **DQ** met the standards for 93.3 percent of dental service types.

The MCOs' greatest challenge was contracting with sufficient pediatric specialists to meet access standards, with two of the three MCOs failing to meet standards for pediatric ophthalmologists (**ACNH** and **NHHF**), allergy/immunology specialists (**ACNH** and **WS**), and developmental-behavioral pediatricians (**ACNH** and **WS**). **WS** also failed to meet the standards for access to pediatric specialists in audiology, orthopedics and orthopedic surgery, plastic surgery, imaging providers, and laboratory services. In addition, **WS** failed to meet several standards because the provider data file they submitted to HSAG lacked data identifying hospitals providing specific services covered by the DHHS standards (e.g., maternity hospitals, neonatal intensive care unit [NICUs], open-heart surgery). HSAG discusses this data issue further in the MCE-specific section below.

As SFY 2024 was the first year of the DO's contract, DHHS monitored the DO's progress monthly as it was building its provider network. The DO met DHHS standards for five dental service types across urban and middle counties, and for four of the five dental service types in rural counties. It failed to meet the standard in rural counties for access to oral maxillofacial surgery services, with only 83.9 percent of members able to access a provider within 120 minutes' drive time.

Network capacity analysis: All three MCOs met the network capacity standards for contracting with 75 percent of the 10 OTP providers identified in DHHS' provider list, in fact contracting with all of the OTP providers. Two of the three MCOs (**NHHF** and **WS**) contracted with 54.2 percent of the listed residential SUD treatment programs, and **ACNH** contracted with 29.2 percent of those programs. Since the list of SUD programs in DHHS' Network.01 report template does not reflect changes in the provider landscape since 11/07/2022, these results are being considered as informational only, and should be interpreted with caution.

Successes

Based on the results of the ISCA combined with the detailed validation of each indicator, the MCEs are doing very well. All MCEs received high confidence ratings for their data, methods, and reporting of the time and distance, network capacity, and access and availability network adequacy indicators. A report of each MCE's specific results and validation ratings was provided to DHHS, and after approval, each MCE was given the opportunity to review its results.

The MCEs' regularly submitted reports indicate they have robust and comprehensive provider networks, with access within time and distance standards. DHHS created the reporting template, which functions as a provider crosswalk and aids the agency in monitoring access to a broad cross section of provider types, services, and facilities. The MCEs appeared to have used the templates properly, with satisfactory application of the State's provider crosswalks and reliable identification of the data elements necessary to report the indicators, while noting that the list of residential SUD treatment programs seemed outdated.

This first year that the State provided dental services under DMCM was a success, with the DO able to provide more than 90 percent of its members access to a full range of dental preventive and restorative services and oral and maxillofacial surgery in urban and middle counties within time or distance standards. However, the DO was unable to meet one standard in rural counties, with 83.9 percent of members having access to oral and maxillofacial surgery within 120 minutes.

All three MCOs met the network capacity standard of contracting with at least 75 percent of the OTP providers listed by DHHS.

Opportunities for Improvement

The MCOs' greatest challenge was contracting with sufficient pediatric specialists of three specific types, with two of the three MCOs failing to meet standards for pediatric ophthalmologists (**ACNH** and **NHHF**), allergy/immunology specialists (**ACNH** and **WS**), and developmental-behavioral pediatricians (**ACNH** and **WS**). Of these, the most significant gap in provider coverage was for pediatric ophthalmologist, with none of the members of **ACNH** or **NHHF** having access within standards.

The DO has an opportunity to improve access to oral maxillofacial surgeons in rural counties.

The network capacity results demonstrated issues with identifying the universe of providers or programs licensed and practicing within the State for Residential SUD treatment programs due to the lapse of time since creation of the list provided in the Network.01 report template. HSAG could not match plan data to several of the listed providers, and some plans reported that providers had closed or otherwise should be removed from the list. HSAG identified only 54.2 percent of the listed providers in any MCO's provider data, raising the possibility that the inability to contract with a number of providers is not due to the MCOs' inability or lack of willingness to contract with providers, but to changes in the landscape of available providers over time due to closures, mergers, or other circumstances. DHHS has the opportunity to improve the accuracy and reliability of these results by updating the list of SUD providers in its report template.

The virtual review sessions revealed that the MCOs had different methodologies for assigning providers to several types of pediatric specialists. The DHHS crosswalk included taxonomy codes to identify several pediatric specialists. Two of the MCOs required the listed taxonomy codes for providers, while one did not, allowing providers with a specialty in the general population who agree to see children to be identified as pediatric specialists. This difference in identifying providers for these categories has led to

some inconsistencies in results among MCOs. If DHHS intends to require the taxonomy codes, it should provide clear instructions to the MCOs.

Statewide Recommendations

- DHHS' network capacity standards for SUD provider types require the MCOs to contract with a minimum percentage of four types of SUD providers or programs licensed and practicing in the state.[3] DHHS prepopulates a list of relevant providers in its template for the Network.01 report, to be completed by the MCOs. HSAG recommends that DHHS update that provider list on at least an annual basis to support a timely, and more meaningful assessment of the capacity of the MCOs' networks to provide these services.
- DHHS should continue to review provider categories for which MCEs did not meet the geographic access standards, with the goal of determining whether failures were the result of a lack of providers, lack of providers willing to contract with Medicaid, or simply providers unwilling to contract with a given MCE. Future analyses could also evaluate the extent to which the MCEs have requested exemptions from DHHS for provider categories for which providers may not be available or willing to contract with the MCEs and DHHS' disposition of those requests.
- DHHS should continue to work with HSAG and the MCEs to improve the quality of reported data. DHHS could encourage MCEs to carefully distinguish between individual and organizational or facility records for provider types that include both individual and organizational or facility providers. For example, HSAG did not accept an MCO's listing of an individual physician as meeting the standard for access to an SUD residential treatment facility.
- In addition to assessing the number, distribution, and availability of providers, DHHS may consider reviewing patient satisfaction survey results and grievance and appeal data to evaluate the degree to which members are satisfied with their access to providers.
- HSAG recommends that the MCEs continue to monitor member access through network adequacy assessments based on the State's expectations.

[3] The SUD providers governed by the network adequacy standards are buprenorphine prescribers, master licensed alcohol and drug counselors (MLADCs), opioid treatment providers (OTPs), and residential SUD treatment programs. Per guidance from DHHS, HSAG only calculated results for OTPs and residential SUD treatment programs during SFY 2024.

2. Validation Results

As mentioned, HSAG conducted a desk review and live virtual review sessions with each of the MCEs to evaluate the information systems, data processing procedures, and the underlying methodology that the MCEs utilized to support their network adequacy indicator reporting. This section includes key findings from each MCE's ISCA.

ACNH

ISCA Findings and Data Validity

HSAG completed an ISCA for **ACNH** and presents the following findings related to the data, methods, and results that the MCE reported for its NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information system data processing procedures that **ACNH** had in place to support network adequacy indicator reporting, which included the following:

- **ACNH** sourced member and provider data from the Enterprise Data Warehouse (EDW) to conduct network adequacy calculation and reporting.
- **ACNH** used Facets as the healthcare benefits administration system to collect and maintain member enrollment and provider data.
- **ACNH** used Cactus as the database management system for storing data related to provider credentialing.

HSAG evaluated the personnel that **ACNH** had in place to support network adequacy indicator reporting, which included the following:

- **ACNH** had two programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had approximately 10 years of experience in the field.

HSAG identified no concerns with **ACNH**'s information system data processing procedures or personnel.

Enrollment System

HSAG evaluated the information system and processes that **ACNH** used to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the State. HSAG's evaluation of **ACNH**'s enrollment system included the following:

- **ACNH** maintained enrollment and eligibility data for Medicaid members within Facets, its healthcare benefits administration system.
- **ACNH** received daily and monthly enrollment files in the 834 file format from DHHS.
- **ACNH** performed monthly reconciliation between Facets and the 834 enrollment data received from DHHS to ensure completeness and accuracy of enrollment data.
- **ACNH** conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - **ACNH** received 834 files six days a week and processed files within 24 hours of receipt in chronological order for each member.
  - **ACNH** received a monthly reconciliation file from DHHS, which it processed and used to reconcile enrollment data between data in Facets and the daily 834 file.
  - **ACNH** loaded the enrollment data into Facets, which used a series of business rules to determine if the member already exists in Facets. If it did not find the member, Facets systematically assigned a new unique member ID to the member. If Facets did locate the member, the member retained his or her originally assigned unique member ID.
  - **ACNH** transmitted the enrollment files daily to **ACNH** contracted vendors, which ensured timely receipt of updated enrollment information.
  - The 834 file contained member enrollment and disenrollment information. Once **ACNH** loaded the 834 file into Facets, Facets flagged any disenrollments or reenrollments that it was unable to process successfully as discrepancies for manual research within the DHHS eligibility portal. The **ACNH** enrollment team managed and researched all discrepancies to resolve them.
- **ACNH**'s system captured and maintained both the state-issued Medicaid ID and a system-generated ID. If the Medicaid ID changed for any reason, **ACNH** used the system-generated ID to link enrollment history.
- **ACNH** identified member demographic updates based on the daily 834 enrollment file received from DHHS.

HSAG identified no concerns with **ACNH**'s enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes that **ACNH** used to capture provider data and identified the following:

- **ACNH** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- **ACNH** had adequate data collection processes in place to ensure completeness and consistency.
- **ACNH** collected data from providers to support the contracting and credentialing process in standardized formats to the extent feasible and appropriate, utilizing a data feed received directly from the Council for Affordable Quality Healthcare (CAQH).

HSAG's evaluation of **ACNH**'s provider data system(s) included the following:

- **ACNH** maintained provider credentialing and network status data in Cactus, **ACNH**'s web-based provider database management system.
- **ACNH** captured state-required provider types in Cactus.
- **ACNH**'s procedures for updating and maintaining provider data included the following:
  - **ACNH** maintained and displayed provider contracted status in an online provider directory made available to members. **ACNH** maintained and updated provider data based on the receipt of the provider application or notification of updates by the provider. Providers could submit updates through various methods such as email, fax, and postal mail. Typically, providers submitted their updates via email.
  - **ACNH** utilized the DHHS Provider Medicaid ID file daily to monitor and reconcile provider adds and deletes.
  - **ACNH** routinely validated provider self-reported National Provider Identification (NPI) numbers against the National Plan & Provider Enumeration System (NPPES) files for any deactivated providers.
  - **ACNH**'s Provider Management Department conducted provider roster reconciliations, including annual provider surveys to confirm and update provider information. **ACNH** also conducted ongoing outreach to review and confirm demographic information. **ACNH** leveraged several outreach methods to ensure timely receipt of updated provider information.
  - **ACNH** reached out to participating hospitals to determine if they were providing a particular service. If the hospital was providing the service, **ACNH** flagged the hospital in the system and then mapped it for network adequacy reporting.
  - Once ACNH fully credentialed a provider, **ACNH** used provider data from Cactus to enrich data in Facets, which **ACNH** then utilized to track providers over time, across multiple locations, and through changes in participation. This information was also accessible in the EDW for network adequacy reporting.

HSAG identified no concerns with **ACNH**'s provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of **ACNH**'s delegated entity data and oversight included the following:

- **ACNH** subcontracted vision services to Avesis, which used the Cadence operating system. Avesis sent provider data to **ACNH** weekly. **ACNH** integrated provider data from Avesis into Facets.
- **ACNH** subcontracted pharmacy services to PerformRx, which sent provider data monthly, and **ACNH** transferred the data to the Facets system.
- **ACNH** maintained oversight of its delegated entities by:
  - Conducting annual audits.

  - Collecting monthly reports in a standardized format, inclusive of contractually required data elements.
  - Holding quarterly joint operations committee meetings to review key performance metrics and results of ongoing monitoring of delegated entity data.
- **ACNH** did not identify any delegated entity network adequacy data-related items requiring corrective action for SFY 2024.

Assessment of Network Adequacy Methods

HSAG assessed **ACNH**'s methodologies for assessing network adequacy.

- **ACNH** used Quest Analytics Suite to calculate and report time and distance indicators as required by the State.
- **ACNH** described sampling methodologies to ensure a statistically valid sample size of the appropriate provider types as required by the State.
- **ACNH** calculated and reported minimum network capacity standards as required by the State.
- **ACNH** selected methods to calculate all indicators that were appropriate to the State Medicaid population(s).

HSAG identified no concerns with **ACNH**'s methods for assessing network adequacy.

Network Adequacy Indicator Reporting of Results

HSAG assessed **ACNH**'s network adequacy indicator reporting processes, and the following summarizes the findings:

- **ACNH** maintained data control procedures to ensure accuracy and completeness of member and provider data, which **ACNH** extracted from its data warehouse for network adequacy reporting. **ACNH** geocoded the data extract using Quest Analytics software using data checks built into Quest Analytics that identified data errors for the analyst to review and address as needed.
- **ACNH** conducted testing on its report creation process when it first adopted the process and regularly verified that it updated the indicators as required by the State. **ACNH** assured report quality and accuracy by following a formally documented process. **ACNH**'s supervisory staff reviewed the results for accuracy, completeness, and reasonability prior to submitting the report to the State.
- To ensure continuity of network adequacy indicator production, **ACNH** maintained an internal shared location where programmers could retrieve the reporting requirements and mapping needed to run and archive the reports.

HSAG identified no concerns with **ACNH**'s network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that **ACNH** used to calculate results generated for each network adequacy indicator in scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that **ACNH** used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Overall, HSAG determined that the **data collection procedures** in place at **ACNH** were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at **ACNH** were:

☒ Acceptable

☐ Not acceptable

Overall, HSAG determined that **ACNH**'s **network adequacy results** were:

☒ Acceptable

☐ Not acceptable

Analytic Findings

HSAG performed independent analyses of **ACNH**'s compliance with time and distance and network capacity standards. This section presents the results.

Time and Distance Standards

DHHS has set a minimum threshold of 90 percent for compliance with the time and distance standards, which can be satisfied if an MCE meets either the time or distance requirement. **ACNH** met the standard for 95.0 percent of the provider categories assessed for SFY 2024.

Table 2-1 displays the percentage of **ACNH**'s members who have the access to care required by contract standards for all applicable provider categories. Red shading indicates that the MCO did not meet minimum geographic access standards for a specific provider category.

Table 2-1—Percentage of Members With Required Access to Care by Provider Category for ACNH

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Primary Care			
Primary Care, Adult	Adults	100.0%	99.9%
Primary Care, Pediatric	Children and adolescents	100.0%	>99.9%

Provider Category	Member Population	Percent of Members With Access Within Time or Distance Standards	
		Time	Distance
Physician Specialists			
Allergist, Adult	Adults	99.9%	98.1%
Allergist/Immunologist, Pediatric	Children and adolescents	81.7%	79.0%
Audiologist, Adult	Adults	100.0%	100.0%
Audiologist, Pediatric	Children and adolescents	100.0%	100.0%
Cardiologist, Adult	Adults	100.0%	100.0%
Cardiologist, Pediatric	Children and adolescents	100.0%	100.0%
Dermatologist, Pediatric	Children and adolescents	100.0%	98.0%
Endocrinologist, Pediatric	Children and adolescents	100.0%	99.5%
Gastroenterologist, Pediatric	Children and adolescents	100.0%	99.5%
General Surgeon	All members	100.0%	100.0%
Neurologist, Adult	Adults	100.0%	100.0%
Neurologist, Pediatric	Children and adolescents	100.0%	99.4%
Obstetrician/Gynecologist or Other Maternity Provider	Females, ages 13 and older	100.0%	100.0%
Oncologist, Adult	Adults	100.0%	100.0%
Ophthalmologist, Adult	Adults	97.6%	95.6%
Ophthalmologist, Pediatric	Children and adolescents	0.0%	0.0%
Optometrist	All members	99.9%	99.6%
Orthopedic Surgeon, Pediatric	Children and adolescents	100.0%	98.0%
Orthopedist, Adult	Adults	100.0%	100.0%
Orthopedist, Pediatric	Children and adolescents	100.0%	98.0%
Otolaryngologist, Adult	Adults	100.0%	>99.9%
Otolaryngologist, Pediatric	Children and adolescents	100.0%	98.0%
Pediatrician, Developmental-Behavioral	Children and adolescents	74.2%	53.0%
Plastic Surgeon, Adult	Adults	93.4%	91.7%
Plastic Surgeon, Pediatric	Children and adolescents	100.0%	98.0%
Podiatry, Adult	Adults	100.0%	100.0%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Psychiatrist, Adult	Adults	100.0%	100.0%
Psychiatrist, Pediatric	Children and adolescents	100.0%	100.0%
Psychologist	All members	100.0%	99.4%
Thoracic Surgeon, Adult	Adults	95.8%	93.7%
Urologist, Adult	Adults	100.0%	100.0%
Urologist, Pediatric	Children and adolescents	100.0%	98.6%
Hospital Services			
Hospital—General Acute Care	All members	100.0%	100.0%
Hospital—Maternity	Females, ages 13 and older	100.0%	>99.9%
Hospital—Level 3/4 Neonatal Intensive Care	All members	100.0%	98.1%
Hospital—Level 1 Major Trauma Treatment	All members	100.0%	98.1%
Hospital—Diagnostic Cardiac Catheterization	All members	98.6%	97.3%
Hospital—Open-Heart Surgery Services	All members	100.0%	98.0%
Hospital—Therapeutic Radiation	All members	95.7%	93.7%
Hospital/Short Term Facility For Inpatient Medical Rehabilitation Services	All members	100.0%	100.0%
Short Term Care Facility for Involuntary Psychiatric Admissions	All members	95.1%	93.2%
General Inpatient Psychiatric	All members	99.2%	96.4%
Diagnostic Services			
CAT Scan Provider	All members	100.0%	100.0%
Imaging Provider (Ultrasound & X-Ray) Provider	All members	100.0%	100.0%
Magnetic Resonance Imaging Center	All members	100.0%	100.0%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Laboratory	All members	100.0%	100.0%
Other Facilities and Services			
Pharmacy	All members	100.0%	99.6%
Durable Medical Equipment (DME)	All members	99.6%	97.9%
Adult Medical Daycare	Adults	99.5%	96.0%
Family Planning	All members, ages 13 and older	100.0%	100.0%
Licensed Renal Dialysis Provider	All members	98.8%	96.1%
Office Based Physical Therapist/Occupational Therapist/Speech Therapist	All members	100.0%	100.0%
Community Mental Health Center	All members	100.0%	100.0%
Hospice	Adults	99.9%	99.6%
Hospice	All members	99.9%	99.6%
Substance Use Disorder (SUD) Services			
SUD Master Licensed Alcohol & Drug Counselor	All members	100.0%	98.5%
Methadone Clinics	All members	95.2%	93.8%
SUD Comprehensive Program	All members	>99.9%	99.8%
SUD Outpatient Program	All members	100.0%	>99.9%

Note: The time and distance standards take into account different driving conditions and average expected driving speeds. For example, for most specialists DHHS requires that 90 percent of members have one provider within 60 minutes or 45 miles. This sometimes produces fairly large differences in the percentage of members with access using the time standard versus the distance standard. The complete list of standards is in Appendix A.

Of the 61 time and distance standards that HSAG assessed, **ACNH** met the standard for 58 standards (95.0 percent). **ACNH** met all standards for primary care, hospital services, diagnostic services, other facilities and services, and SUD services. However, some **ACNH** members did not have access within the standards to pediatric allergists/immunologists or development-behavioral pediatricians, and **ACNH** did not identify a pediatric ophthalmologist in its network.

Network Capacity Analysis

Table 2-2 displays the statewide network capacity analysis results for **ACNH** (i.e., the percentage of providers or programs licensed and practicing within New Hampshire that DHHS identified in its Network.01 report template). The residential SUD treatment program results should be considered for information only and interpreted with caution.

Table 2-2—Statewide Network Capacity Analysis Results for ACNH

Provider Category	DHHS Standard	Number (%) of Listed Providers Contracted
OTP	75% of 10 listed providers	10 (100.0%)
Residential SUD Treatment Program	50% of 24 listed programs	7 (29.2%)

ACNH Validation Ratings

HSAG synthesized the ISCA and analytic results to arrive at a validation rating indicating HSAG's overall confidence that **ACNH** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table 2-3 summarizes HSAG's validation ratings for **ACNH** by indicator type, with **ACNH** receiving high confidence for all access and availability, network capacity, and time and distance indicators.

Table 2-3—Summary of ACNH Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and Availability (N=44)	100%	0%	0%	0%
Network Capacity (N=2)	100%	0%	0%	0%
Time and Distance (N=61)	100%	0%	0%	0%

Strengths, Opportunities for Improvement, and Recommendations

By assessing **ACNH**'s performance and NAV reporting process, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: ACNH had sufficient policies and procedures in place to ensure timeliness and accuracy in data collection and management of data used to inform network adequacy standards and indicators calculation.

Strength #2: ACNH had sufficient policies and procedures in place to ensure that it uses sound methods to assess the adequacy of its managed care networks as required by the State and accurately reported results to the State in the required format. HSAG has high confidence in **ACNH**'s ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.

Strength #3: ACNH met the State's time and distance standards for 58 of 61 provider categories.

Opportunities for Improvement and Recommendations

Opportunity #1: HSAG did not identify any specific opportunities related to the data collection and management processes **ACNH** had in place to inform network adequacy standards and indicator calculations.

Recommendation: N/A

Opportunity #2: ACNH did not meet the 90 percent time and distance standards for three provider categories: pediatric allergists/immunologists, developmental-behavioral pediatrician specialists, and pediatric ophthalmologists.

Recommendation: HSAG recommends that **ACNH** maintain current levels of access to care and continue to address network gaps for the following provider categories: pediatric allergists/immunologists, developmental-behavioral pediatrician specialists, and pediatric ophthalmologists.

NHHF

ISCA Findings and Data Validity

HSAG completed an ISCA for **NHHF** and presents the following findings related to the data, methods, and results that the MCE reported for its NAV-.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information system data processing procedures that **NHHF** had in place to support network adequacy indicator reporting, which included the following:

- **NHHF** used Amysis as the database management system to maintain comprehensive member demographic and eligibility information.
- **NHHF** used Amysis and Portico as the database management system to capture provider data.
- **NHHF** used CenProv, a Centene-specific database, as the database management system to track provider credentialing data.

HSAG evaluated the personnel that **NHHF** had in place to support network adequacy indicator reporting, which included the following:

- **NHHF** had one programmer trained and capable of supporting network adequacy reporting activities. The programmer had approximately 2.5 years of experience in the field.

HSAG identified no concerns with **NHHF**'s information system data processing procedures or personnel.

Enrollment System

HSAG evaluated the information system and processes that **NHHF** used to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the State. HSAG's evaluation of the **NHHF**'s enrollment system included the following:

- **NHHF** used Amysis to capture enrollment information from the States's secure file transfer protocol (SFTP) site daily in 834 format.
- Upon receipt of the daily 834 enrollment file from DHHS, the electronic data interchange (EDI) team at Centene, the parent company for **NHHF**, processed the enrollment files on behalf of **NHHF**. Eligibility files included any new members, terminating members, and changes to existing members.
- **NHHF** conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - Monthly, **NHHF** received a file from the State, which **NHHF** used for reconciliation of the daily 834 files to ensure accuracy and completeness.

  - **NHHF**'s IT department systematically loaded the 834 file into Amysis and flagged data conflicts, which generated an "errors out" report for manual review and processing.
  - Every month **NHHF** ran a mid-compare file, a list of all active membership for the State's review. The State reviewed the list for any discrepancies and provided **NHHF** with state-identified findings and corrections.
  - **NHHF** reviewed the entire 834 history of each member with identified discrepancies in eligibility dates to determine the cause of the discrepancy. **NHHF** manually corrected any items processed in error.
- **NHHF**'s system generated a member ID number based on the Medicaid ID on the 834 file. **NHHF** generated reports to assist in identifying any duplicate members. **NHHF** merged duplicate members within the system and retained both Medicaid IDs for those members within its information systems as well as all associated membership history.
- The 834 enrollment file from the State provided **NHHF**'s identified member residence. In situations of homelessness, the State typically assigned a service link location. **NHHF** was able to track historical member address data when it detected changes.

HSAG identified no concerns with **NHHF**'s enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes that **NHHF** used to capture provider data and identified the following:

- **NHHF** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- **NHHF** had adequate data collection processes in place to ensure completeness and consistency.
- **NHHF** collected data from providers to support the contracting and credentialing process in standardized formats, utilizing the Provider Data Management folder system, which entailed a receipt of contract and credentialing materials.

HSAG's evaluation of **NHHF**'s provider data system(s) included the following:

- **NHHF** used Amisys and Portico to capture provider data for its medical providers.
- **NHHF** used CenProv, a Centene-specific database, to track all provider credentialing data.
- **NHHF** captured state-required provider types in Amisys and Portico.
- **NHHF**'s procedures for updating and maintaining provider data included the following:
  - **NHHF** received information for contracted providers through its provider data management (PDM) folder system, which included documentation of receipt of the contract and credentialing materials.

- **NHHF** obtained provider data updates through several methods, such as email vendor identification or the provider-facing portal. Regardless of the method of receipt, **NHHF** entered the updates into CenProv, which subsequently flowed into Portico and Amysis.
- **NHHF** stored provider demographic information in Portico and Amysis, which had the capability to track providers over time, across multiple office locations, and through changes in participation in the **NHHF** network.
- **NHHF** utilized Veda a subcontracted vendor which cleanses corporate provider directories, to scrub provider data quarterly. **NHHF** updated its systems with any changes based on updates that Veda identified during the scrubbing process. Veda also identified providers or organizations excluded from the Medicaid program during its quarterly review.
- **NHHF** required its providers to report updated information regularly.

HSAG identified no concerns with **NHHF**'s provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of **NHHF**'s delegated entity data and oversight included the following:

- **NHHF** subcontracted vision services to Envolve Vision and pharmacy services to Centene Pharmacy Services.
- **NHHF** maintained oversight of its delegated entities by:
  - Requiring delegated entities to complete network adequacy calculations and submit data files to **NHHF**'s senior reporting data analyst for review and evaluation. This analyst reviewed data file submissions to ensure consistency, track data over time, and identify any shifts in the outcomes and any notable changes resulting in necessary follow-up. If the analyst identified any issues, **NHHF** followed up with the vendor to resolve the issue in a timely manner.
- **NHHF** did not identify any delegated entity network adequacy data-related items requiring corrective action for SFY 2024.

Assessment of Network Adequacy Methods

HSAG assessed **NHHF**'s methodologies for assessing network adequacy.

- **NHHF** used Quest Analytics Suite to calculate and report time and distance indicators as required by the State.
- **NHHF** described sampling methodologies to ensure a statistically valid sample size of the appropriate provider types as required by the State.
- **NHHF** calculated and reported minimum network capacity standards as required by the State.
- **NHHF** selected methods to calculate all indicators that were appropriate to the State Medicaid population(s).

HSAG identified no concerns with **NHHF**'s methods for assessing network adequacy.

Network Adequacy Indicator Reporting of Results

HSAG assessed **NHHF**'s network adequacy indicator reporting processes, and the following summarizes the findings:

- **NHHF** maintained data control procedures to ensure accuracy and completeness of data merges from all data sources and systems. **NHHF** used data checks built into Quest Analytics that identified data errors for the analyst to review and address as needed.
- **NHHF** performed data reasonability checks by conducting biweekly analyses and comparing results to the previous report to ensure the reasonableness of the results.
- To ensure continuity of network adequacy indicator production, **NHHF** reviewed all reports that identified any new network adequacy gaps with senior leadership to ensure they represented a true gap and not a reporting error.

HSAG identified no concerns with **NHHF**'s network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that **NHHF** used to calculate results generated for each network adequacy indicator in scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that **NHHF** used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Overall, HSAG determined that the **data collection procedures** in place at **NHHF** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at **NHHF** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that **NHHF**'s **network adequacy results** were:

☒ Acceptable
☐ Not acceptable

Analytic Findings

HSAG performed independent analyses of **NHHF**'s compliance with time and distance and network capacity standards. This section presents the results.

Time and Distance Standards

DHHS has set a minimum threshold of 90 percent for compliance with the time and distance standards, which can be satisfied if an MCE meets either the time or distance requirement. **NHHF** met the standard for 98.4 percent of the provider categories for the time and distance standards assessed for SFY 2024.

Table 2-4 displays the percentage of **NHHF**'s members who have the access to care required by contract standards for all applicable provider categories. Red shading indicates the MCO did not meet minimum time and distance standards for a specific provider category.

Table 2-4—Percentage of Members With Required Access to Care by Provider Category for NHHF

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Primary Care			
Primary Care, Adult	Adults	100.0%	99.9%
Primary Care, Pediatric	Children and adolescents	100.0%	99.9%
Physician Specialists			
Allergist, Adult	Adults	99.9%	97.6%
Allergist/Immunologist, Pediatric	Children and adolescents	98.8%	87.3%
Audiologist, Adult	Adults	100.0%	100.0%
Audiologist, Pediatric	Children and adolescents	100.0%	100.0%
Cardiologist, Adult	Adults	100.0%	100.0%
Cardiologist, Pediatric	Children and adolescents	100.0%	100.0%
Dermatologist, Pediatric	Children and adolescents	>99.9%	97.2%
Endocrinologist, Pediatric	Children and adolescents	>99.9%	97.2%
Gastroenterologist, Pediatric	Children and adolescents	>99.9%	97.2%
General Surgeon	All members	100.0%	100.0%
Neurologist, Adult	Adults	100.0%	100.0%
Neurologist, Pediatric	Children and adolescents	>99.9%	97.2%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Obstetrician/Gynecologist or Other Maternity Provider	Females, ages 13 and older	100.0%	>99.9%
Oncologist, Adult	Adults	100.0%	100.0%
Ophthalmologist, Adult	Adults	99.9%	99.2%
Ophthalmologist, Pediatric	Children and adolescents	0.0%	0.0%
Optometrist	All members	100.0%	100.0%
Orthopedic Surgeon, Pediatric	Children and adolescents	99.9%	70.1%
Orthopedist, Adult	Adults	100.0%	100.0%
Orthopedist, Pediatric	Children and adolescents	100.0%	100.0%
Otolaryngologist, Adult	Adults	100.0%	>99.9%
Otolaryngologist, Pediatric	Children and adolescents	>99.9%	97.2%
Pediatrician, Developmental-Behavioral	Children and adolescents	91.6%	78.1%
Plastic Surgeon, Adult	Adults	99.6%	98.7%
Plastic Surgeon, Pediatric	Children and adolescents	100.0%	100.0%
Podiatry, Adult	Adults	100.0%	>99.9%
Psychiatrist, Adult	Adults	100.0%	100.0%
Psychiatrist, Pediatric	Children and adolescents	100.0%	99.5%
Psychologist	All members	100.0%	99.8%
Thoracic Surgeon, Adult	Adults	94.6%	94.1%
Urologist, Adult	Adults	100.0%	>99.9%
Urologist, Pediatric	Children and adolescents	>99.9%	97.2%
Hospital Services			
Hospital—General Acute Care	All members	100.0%	100.0%
Hospital—Maternity	Females, ages 13 and older	99.9%	99.2%
Hospital—Level 3/4 Neonatal Intensive Care	All members	>99.9%	97.2%
Hospital—Level 1 Major Trauma Treatment	All members	100.0%	100.0%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Hospital—Diagnostic Cardiac Catheterization	All members	98.0%	95.0%
Hospital—Open-Heart Surgery Services	All members	>99.9%	97.2%
Hospital—Therapeutic Radiation	All members	93.2%	91.7%
Hospital/Short Term Facility For Inpatient Medical Rehabilitation Services	All members	100.0%	99.6%
Short Term Care Facility for Involuntary Psychiatric Admissions	All members	93.4%	91.6%
General Inpatient Psychiatric	All members	98.8%	96.3%
Diagnostic Services			
CAT Scan Provider	All members	100.0%	100.0%
Imaging Provider (Ultrasound & X-Ray) Provider	All members	100.0%	100.0%
Magnetic Resonance Imaging Center	All members	100.0%	100.0%
Laboratory	All members	100.0%	100.0%
Other Facilities and Services			
Pharmacy	All members	100.0%	99.4%
Durable Medical Equipment (DME)	All members	100.0%	>99.9%
Adult Medical Daycare	Adults	98.6%	93.2%
Family Planning	All members, ages 13 and older	100.0%	100.0%
Licensed Renal Dialysis Provider	All members	100.0%	>99.9%
Office Based Physical Therapist/Occupational Therapist/Speech Therapist	All members	100.0%	100.0%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Community Mental Health Center	All members	100.0%	100.0%
Hospice	Adults	100.0%	>99.9%
Hospice	All members	100.0%	>99.9%
Substance Use Disorder (SUD) Services			
SUD Master Licensed Alcohol & Drug Counselor	All members	99.3%	92.5%
Methadone Clinics	All members	98.8%	95.2%
SUD Comprehensive Program	All members	99.9%	99.5%
SUD Outpatient Program	All members	100.0%	99.9%

Note: The time and distance standards take into account different driving conditions and average expected driving speeds. For example, for most specialists DHHS requires that 90 percent of members have one provider within 60 minutes or 45 miles. This sometimes produces fairly large differences in the percentage of members with access using the time standard versus the distance standard. The complete list of standards is in Appendix A.

Of the 61 time and distance standards that HSAG assessed, **NHHF** met the standard for 60 (98.4 percent). **NHHF** met the standards for all primary care, hospital services, diagnostic services, other facilities and services, and SUD services. However, **NHHF** did not identify a pediatric ophthalmologist in its network.

Network Capacity Analysis

Table 2-5 displays the statewide network capacity analysis results for **NHHF** (i.e., the percentage of providers or programs licensed and practicing within New Hampshire that DHHS identified in its Network.01 report template). The residential SUD treatment program results should be considered for information only and interpreted with caution.

Table 2-5—Statewide Network Capacity Analysis Results for NHHF

Provider Category	DHHS Standard	Number (%) of Listed Providers Contracted
OTP	75% of 10 listed providers	10 (100.0%)
Residential SUD Treatment Program	50% of 24 listed programs	13 (54.2%)

NHHF Validation Ratings

HSAG synthesized the ISCA and analytic results to arrive at a validation rating indicating HSAG's overall confidence that **NHHF** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table 2-6 summarizes HSAG's validation ratings for **NHHF**, by indicator type, with **NHHF** receiving high confidence for access and availability, network capacity, and time and distance indicators.

Table 2-6—Summary of NHHF Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and Availability (N=44)	100%	0%	0%	0%
Network Capacity (N=2)	100%	0%	0%	0%
Time and Distance (N=61)	100%	0%	0%	0%

Strengths, Opportunities for Improvement, and Recommendations

By assessing **NHHF**'s performance and NAV reporting process, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: NHHF conducted ongoing monitoring of network adequacy by generating biweekly reports to ensure compliance and address gaps.

Strength #2: NHHF had sufficient policies and procedures in place to ensure timeliness and accuracy in data collection and management of data used to inform network adequacy standards and indicators calculation.

Strength #3: NHHF met the State's time and distance standards for 60 of 61 provider categories.

Opportunities for Improvement and Recommendations

Opportunity #1: HSAG observed that **NHHF** had minimal programmer staff trained and capable of supporting network adequacy data analysis and oversight of contracted vendors performing network adequacy calculations.

Recommendation: HSAG recommends that **NHHF** enhance its vendor oversight to ensure vendors are knowledgeable and can support network adequacy analyses, and consider cross-training **NHHF** staff to increase internal knowledge and capabilities to support ongoing network adequacy data monitoring.

Opportunity #2: **NHHF** did not meet the 90 percent time and distance standard for one provider category, pediatric ophthalmologist.

Recommendation: HSAG recommends that **NHHF** maintain the current level of access to care and continue to address network gaps for pediatric ophthalmologists.

WS

ISCA Findings and Data Validity

HSAG completed an ISCA for **WS** and presents the following findings related to data, methods, and results that the MCE reported for its NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information system data processing procedures that **WS** had in place to support network adequacy indicator reporting, which included the following:

- **WS** used Facets as the database management system to maintain comprehensive demographic and eligibility information.
- **WS** used Onyx and Visual Cactus as the data base management systems to store and manage provider data.
- **WS** used an EDW as a centralized data repository to produce member- and provider-specific data files used to inform network adequacy calculation and reporting.

HSAG evaluated the personnel that **WS** had in place to support network adequacy indicator reporting, which included the following:

- **WS** had two programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had 15 years of experience in the field.

HSAG identified no concerns with **WS**'s information system data processing procedures and personnel.

Enrollment System

HSAG evaluated the information system and processes that **WS** used to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the State. HSAG's evaluation of **WS**'s enrollment system included the following:

- **WS** received daily enrollment files in the 834 file format from DHHS and loaded them directly into **WS**'s member enrollment database management system, Facets. **WS** ensured that required data fields were present before loading any membership data into Facets.
- **WS** conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - **WS**'s trained its enrollment representatives to use the information reflected on the New Hampshire Eligibility Verification Portal to verify eligibility data. If the portal did not provide adequate information, **WS** escalated the issue to a department supervisor or manager who worked directly with DHHS to obtain resolution.

  - **WS** performed monthly reconciliation between Facets and DHHS data to ensure completeness and accuracy of enrollment data.
- **WS** assigned a unique identifier for each member and linked the member to the unique DHHS-assigned identifier. **WS** validated member enrollment monthly and reassigned the same member ID number when a member disenrolled and reenrolled months or years later.

WS staff documented member demographic changes in the call center notes and tracked the changes in Facets within the audit history record. **WS** staff verified the changes by matching member demographic information to data in the Medicaid Management Information System (MMIS) look-up tool. HSAG identified no concerns with **WS**'s enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes that **WS** used to capture provider data and identified the following:

- **WS** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- **WS** had adequate data collection processes in place to ensure completeness and consistency.
- **WS** collected data from providers to support the contracting and credentialing process in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of **WS**'s provider data system(s) included the following:

- **WS** delegated provider credentialing to Verisys, an organization that is part of the Credentials Verification Organization (CVO). Verisys used the CVOne system to document required primary source verification (PSV) of provider information for credentialing.
- **WS** also used Visual Cactus as its source system to document the final verification of all information in each provider's credentialing application, as well as the final credentialing completion date.
- **WS** delegated provider enrollment to Dartmouth Hitchcock Medical Center (DHMC). DHMC received provider credentialing information via Microsoft Excel files, and provider enrollment staff completed onboarding with the data. Once the provider was enrolled, **WS** loaded provider data into both Onyx and Visual Cactus systems.
- **WS** captured state-required provider types and specialties in the Onyx and Visual Cactus systems.
- **WS**'s procedures for updating and maintaining provider data included the following:
  - **WS** considered a credentialing application to be clean and complete once Verisys collected the required data elements that accompanied or were included in the provider's CAQH application. The credentialing team completed PSV in accordance with all elements requiring verification for finalizing the credentialing process for providers' enrollment in the **WS** network. If their data changed, providers were contractually required to report all changes such as name, NPI,

Taxpayer Identification Number (TIN), locations, and phone numbers within 30 days in advance of the change.
  - The **WS** Provider Relations Department met with providers quarterly to review information for accuracy.

HSAG identified no concerns with **WS**'s provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of **WS**'s delegated entity data and oversight included the following:

- **WS** subcontracted provider credentialing to Verisys, delegated provider enrollment to DHMC, and delegated behavioral health services to Carelon.
- **WS** maintained oversight of its delegated entities by:
  - Contractually requiring vendors to ensure data **WS** receives are complete and accurate.
  - Reviewing data against prior submissions, where applicable.

Assessment of Network Adequacy Methods

HSAG assessed **WS**'s methodologies for assessing network adequacy .

- **WS** used Microsoft SQL Server and Quest Analytics to calculate and report time and distance indicators as required by the State.
- **WS** described appropriate sampling methodologies to ensure a statistically valid random sample of the appropriate provider types as required by the State.
- **WS** calculated minimum network capacity standards as required by the State.
- **WS** selected methods to calculate all indicators that were appropriate to the State Medicaid population(s).

HSAG identified no concerns with **WS**'s methods for assessing network adequacy.

Network Adequacy Indicator Reporting of Results

HSAG assessed **WS**'s network adequacy indicator reporting processes, and the following summarizes the findings:

- **WS** conducted data reasonability checks by comparing all results to the previous years' results.
- **WS** maintained network adequacy indicator reports by saving all reports with a YYMM format. **WS** had internal backups to ensure that it maintained all materials associated the network adequacy reports.

- To ensure continuity of network adequacy indicator production, **WS** reviewed all results against the previous years' results and with the contracting team.

HSAG identified no concerns with **WS**'s network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that **WS** used to calculate results generated for each network adequacy indicator in scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that **WS** used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Overall, HSAG determined that the **data collection procedures** in place at **WS** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at **WS** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that **WS**'s **network adequacy results** were:

☒ Acceptable
☐ Not acceptable

Analytic Findings

HSAG performed independent analyses of **WS**'s compliance with time and distance and network capacity standards. This section presents the results.

Time and Distance Standards

DHHS has set a minimum threshold of 90 percent for compliance with the time and distance standards, which can be satisfied if the MCE meets either the time or distance requirement. **WS** met the standards for 73.8 percent of the provider categories for the time and distance standards assessed for SFY 2024.

Table 2-7 displays the percentage of **WS**'s members who have the access to care required by contract standards for all applicable provider categories. Red shading indicates the MCO did not meet minimum geographic access standards for a specific provider category.

Table 2-7—Percentage of Members With Required Access to Care by Provider Category for WS

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Primary Care			
Primary Care, Adult	Adults	100.0%	>99.9%
Primary Care, Pediatric	Children and adolescents	100.0%	97.7%
Physician Specialists			
Allergist, Adult	Adults	95.1%	93.4%
Allergist/Immunologist, Pediatric	Children and adolescents	78.0%	71.8%
Audiologist, Adult	Adults	100.0%	100.0%
Audiologist, Pediatric	Children and adolescents	0.0%	0.0%
Cardiologist, Adult	Adults	100.0%	100.0%
Cardiologist, Pediatric	Children and adolescents	100.0%	100.0%
Dermatologist, Pediatric	Children and adolescents	>99.9%	98.0%
Endocrinologist, Pediatric	Children and adolescents	>99.9%	99.3%
Gastroenterologist, Pediatric	Children and adolescents	>99.9%	98.2%
General Surgeon	All members	100.0%	100.0%
Neurologist, Adult	Adults	100.0%	99.9%
Neurologist, Pediatric	Children and adolescents	>99.9%	99.3%
Obstetrician/Gynecologist or Other Maternity Provider	Females, ages 13 and older	100.0%	100.0%
Oncologist, Adult	Adults	99.9%	99.6%
Ophthalmologist, Adult	Adults	99.9%	99.5%
Ophthalmologist, Pediatric	Children and adolescents	100.0%	100.0%
Optometrist	All members	100.0%	100.0%
Orthopedic Surgeon, Pediatric	Children and adolescents	0.0%	0.0%
Orthopedist, Adult	Adults	100.0%	100.0%
Orthopedist, Pediatric	Children and adolescents	0.0%	0.0%
Otolaryngologist, Adult	Adults	100.0%	>99.9%
Otolaryngologist, Pediatric	Children and adolescents	92.2%	81.6%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Pediatrician, Developmental-Behavioral	Children and adolescents	71.3%	49.2%
Plastic Surgeon, Adult	Adults	93.0%	91.4%
Plastic Surgeon, Pediatric	Children and adolescents	0.0%	0.0%
Podiatry, Adult	Adults	100.0%	100.0%
Psychiatrist, Adult	Adults	99.8%	98.9%
Psychiatrist, Pediatric	Children and adolescents	100.0%	100.0%
Psychologist	All members	99.8%	97.2%
Thoracic Surgeon, Adult	Adults	95.7%	94.8%
Urologist, Adult	Adults	100.0%	100.0%
Urologist, Pediatric	Children and adolescents	>99.9%	98.0%
Hospital Services			
Hospital—General Acute Care	All members	100.0%	100.0%
Hospital—Maternity	Females, ages 13 and older	0.0%	0.0%
Hospital—Level 3/4 Neonatal Intensive Care	All members	0.0%	0.0%
Hospital—Level 1 Major Trauma Treatment	All members	0.0%	0.0%
Hospital—Diagnostic Cardiac Catheterization	All members	0.0%	0.0%
Hospital—Open-Heart Surgery Services	All members	0.0%	0.0%
Hospital—Therapeutic Radiation	All members	66.0%	59.4%
Hospital/Short Term Facility For Inpatient Medical Rehabilitation Services	All members	94.7%	92.3%
Short Term Care Facility for Involuntary Psychiatric Admissions	All members	0.0%	0.0%
General Inpatient Psychiatric	All members	99.9%	97.3%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Diagnostic Services			
CAT Scan Provider	All members	0.0%	0.0%
Imaging Provider (Ultrasound & X-Ray) Provider	All members	39.3%	29.5%
Magnetic Resonance Imaging Center	All members	94.6%	93.2%
Laboratory	All members	84.6%	88.0%
Other Facilities and Services			
Pharmacy	All members	100.0%	99.6%
Durable Medical Equipment (DME)	All members	>99.9%	99.8%
Adult Medical Daycare	Adults	99.2%	93.9%
Family Planning	All members, ages 13 and older	98.1%	95.9%
Licensed Renal Dialysis Provider	All members	100.0%	>99.9%
Office Based Physical Therapist/Occupational Therapist/Speech Therapist	All members	100.0%	100.0%
Community Mental Health Center	All members	100.0%	100.0%
Hospice	Adults	99.9%	99.5%
Hospice	All members	>99.9%	99.6%
Substance Use Disorder (SUD) Services			
SUD Master Licensed Alcohol & Drug Counselor	All members	99.9%	94.4%
Methadone Clinics	All members	95.2%	93.8%
SUD Comprehensive Program	All members	95.1%	93.9%
SUD Outpatient Program	All members	98.2%	97.5%

Note: The time and distance standards take into account different driving conditions and average expected driving speeds. For example, for most specialists DHHS requires that 90 percent of members have one provider within 60 minutes or 45 miles. This sometimes produces fairly large differences in the percentage of members with access using the time standard versus the distance standard. The complete list of standards is in Appendix A.

Of the 61 time and distance standards that HSAG assessed, **WS** met the standard for 45 (73.8 percent). **WS** met all standards for primary care, other facilities and services such as pharmacies and DME providers, and SUD services. **WS** did not meet the standards for several physician specialists or for several categories of hospital and diagnostic services due to issues related to the data **WS** submitted to HSAG.

Among the physician specialist provider categories, **WS** did not meet the standards for the following pediatric provider categories: allergist/immunologist, audiologist, orthopedic surgeon, orthopedist, plastic surgeon, and developmental-behavioral pediatrician. The DHHS crosswalk defined several of these specialties through applicable taxonomy codes. Based on information HSAG collected during the virtual review, **WS** did not collect the taxonomy codes but identified these providers using a combination of provider specialty and input from the provider regarding whether or not the provider sees pediatric patients. This explains in large part the discrepancy between the plan's results reported in the Network.01 report and HSAG's results which used the taxonomy codes from DHHS' crosswalk definition.

For other provider types, **WS** did not provide any data in the provider file it submitted to HSAG that identified providers in seven of the 14 hospital service and diagnostic service provider categories. During the virtual review, **WS** was able to identify providers in these categories (e.g., hospital-maternity or computed tomography scan [CT or CAT scan providers]) but had not identified them in the data submitted to HSAG. Thus, although HSAG's analytic results show several failed standards, these failures are a result of **WS** omitting the data requested in the provider file, and do not reflect **WS**'s provider network. **WS's** validation scores reflected these data issues but still met the 90 percent score required to warrant HSAG's high confidence in the accuracy and reliability of the results, as discussed further in the "WS Validation Ratings" section.

Network Capacity Analysis

Table 2-8 displays the statewide network capacity analysis results for **WS** (i.e., the percentage of providers or programs licensed and practicing within New Hampshire that DHHS identified in its Network.01 report template. The residential SUD treatment program results should be considered for information only and interpreted with caution.

Table 2-8—Statewide Network Capacity Analysis Results for WS

Provider Category	DHHS Standard	Number (%) of Listed Providers Contracted
OTP	75% of 10 listed providers	10 (100.0%)
Residential SUD Treatment Program	50% of 24 listed programs	13 (54.2%)

WS Validation Ratings

HSAG synthesized the ISCA and analytic results to arrive at a validation rating indicating HSAG's overall confidence that **WS** used acceptable methodology for all phases of design, data collection,

analysis, and interpretation of each network adequacy indicator. Table 2-9 summarizes HSAG's validation ratings for **WS** by indicator type, with **WS** receiving high confidence for all indicators.

Table 2-9—Summary of WS Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and Availability (N=44)	100%	0%	0%	0%
Network Capacity (N=2)	100%	0%	0%	0%
Time and Distance (N=61)	100%	0%	0%	0%

Strengths, Opportunities for Improvement, and Recommendations

By assessing **WS**'s performance and NAV reporting process, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: WS had sufficient policies and procedures in place to ensure timeliness and accuracy in data collection and management of data used to inform network adequacy standards and indicators calculation.

Opportunities for Improvement and Recommendations

Opportunity #1: HSAG did not identify any specific opportunities related to the data collection and management processes **WS** had in place to inform network adequacy standard and indicator calculations.

Recommendation: N/A

Opportunity #2: WS did not meet the 90 percent time and distance standards for several pediatric specialists. HSAG learned during the virtual review sessions that **WS** did not track taxonomy codes as DHHS recommended in its crosswalk. Instead, the MCO identified and reported providers who specialize in certain general areas (e.g. orthopedic surgery) and accept children as patients.

Recommendation: HSAG recommends that **WS** maintain current levels of access to care and continue to address network gaps for the following provider categories: pediatric allergist/immunologist, audiologist, orthopedic surgeon, orthopedist, and plastic surgeon as well as developmental behavioral pediatricians. **WS** should also consider collecting and using taxonomy codes in accordance with DHHS standards.

DQ

ISCA Findings and Data Validity

HSAG completed an ISCA for **DQ** and presents the following findings related to the data, methods, and results that the DO reported for its NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information system data processing procedures that **DQ** had in place to support network adequacy indicator reporting, which included the following:

- **DQ** used Windward as the database management system to collect and maintain provider and member enrollment and eligibility data.
- **DQ** used Cactus as the database management system to store data related to provider credentialing.
- **DQ** sourced membership and provider data from its Enterprise Reporting structure, which generated a Multi-Use Directory Report (provider file) and Active Membership Detail Report (membership file) for integration into **DQ**'s GeoAccess software, Quest Analytics.

HSAG evaluated the personnel that **DQ** had in place to support network adequacy indicator reporting, which included the following:

- **DQ** had eight programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had approximately 10 years of experience in the field.

HSAG identified no concerns with **DQ**'s information system data processing procedures or personnel.

Enrollment System

HSAG evaluated the information system and processes that **DQ** used to capture enrollment data for members to confirm that the system was capable of collecting data on member characteristics as specified by the State. HSAG's evaluation of **DQ**'s enrollment system included the following:

- **DQ** received enrollment and eligibility data for Medicaid members daily and monthly from the State, which included member effective and termination dates, via an SFTP site.
- **DQ** processed enrollment files daily through its proprietary electronic enrollment process and updated any changes in real-time in Windward.
- **DQ** received full files once per month and daily change files in the 834 file format from DHHS, processed enrollment files through Windward, and updated enrollment changes in near real-time.
- **DQ** conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:

  - **DQ** used the first full 834 file of the month to audit and verify coverage for members enrolled in Windward.
  - **DQ** performed monthly reconciliation between Windward and the 834 enrollment data received from DHHS to ensure completeness and accuracy of enrollment data.
  - **DQ** performed data integrity and accuracy testing between source systems and the EDW using QuerySurge, a tool designed to identify any variances that the DO needed to address to ensure data completeness.
- The **DQ** system captured and maintained both the state-issued Medicaid ID and system-generated ID.
- **DQ** identified member demographic updates based on the 834 file that DHHS provided.
- **DQ** used the 834 file to determine residence addresses. In the case of homelessness or PO Box, **DQ** would leave the residential address blank, as this was not a required field.

HSAG identified no concerns with **DQ**'s enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes that **DQ** used to capture provider data and identified the following:

- **DQ** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- **DQ** had adequate data collection processes in place to ensure completeness and consistency.
- **DQ** collected data from providers to support the contracting and credentialing process in standardized formats to the extent feasible and appropriate.

HSAG's evaluation of **DQ**'s provider data system(s) included the following:

- **DQ** maintained provider credentialing data in Cactus.
- **DQ** maintained provider network status data in Windward.
- **DQ**'s credentialing specialist completed provider credentialing for primary dental providers (PDPs) and specialty dental providers (SPDs) using the Intelex workflow system.
- **DQ**'s credentialing specialist reviewed the provider's CAQH standard application for accuracy and process verification. Once the credentialing specialist completed the review, **DQ** sent the files via a ticket process to a credentialing queue for the credentialing specialist to complete the provider credentialing process in Cactus. If the specialist discovered any errors, the provider credentialing process would pend until **DQ** received the needed files and the provider information was accurate.
- **DQ**'s dental director signed off on clean applications, and **DQ** notified the provider of enrollment via a welcome letter.

- **DQ** loaded and maintained provider network documentation in Windward for claims payment. The Provider Operations Team determined Medicaid enrollment prior to loading the provider details into Windward.
- **DQ** loaded one specialty for each provider and indicated the specialty in Windward. If a provider had a second specialty listed for a different location, **DQ** would assign the specialty to a different address in Windward. In Cactus, **DQ** would indicate multiple specialties as a provider having a "Primary" and a "Secondary" specialty.
- In Windward, **DQ** was able to access a specialist view to decipher whether the provider was practicing as a PDP or SDP for each location listed.
- **DQ** extracted data from Cactus and Windward for timely credentialing reporting. The credentialing progress start date was the date that **DQ** received the clean, complete application in Cactus. The end date was the date that **DQ** sent the provider notification of enrollment via the welcome letter. **DQ** tracked the start and end dates and filtered them by general providers and specialists.
- **DQ**'s procedures for updating and maintaining provider data included the following:
  - **DQ** populated and updated the addresses, if needed, in the provider data information field in Windward first, and then updated the addresses in Cactus.
  - When provider data changed regarding new addresses or when a provider added an office location, the provider received a PDF fillable form via email or fax, which **DQ** required the provider to complete. Once the provider completed the update form, ServiceNow sent a ticket to the provider operations team, and **DQ** updated the information directly in Windward.
  - **DQ** had control processes built into Windward that prevented duplicate provider locations. Built-in controls included the use of the TIN search bar which allowed **DQ** staff to either choose an existing TIN to avoid duplicates or create a new location that **DQ** attached to the provider's list of locations when updating provider data information.
  - **DQ** verified service locations and provider phone numbers through a quarterly validation process.

HSAG identified no concerns with **DQ**'s provider data capture, data processing, data integration, data storage, or data reporting.

Delegated Entity Data and Oversight

HSAG's assessment of **DQ**'s delegated entity data and oversight included the following:

- **DQ** did not rely on any external delegated entity data for the purpose of network adequacy indicator reporting during the reporting period in scope of review.

Assessment of Network Adequacy Methods

HSAG assessed **DQ**'s methodologies for assessing network adequacy.

- **DQ** used Quest Analytics to calculate and report time and distance indicators as required by the State.
- **DQ** described appropriate sampling methodologies to ensure a statistically valid sample size, random selection of providers, and systematic documentation and calculation of survey results as required by the State.
- **DQ** selected methods to calculate all indicators that were appropriate to the State Medicaid population(s).

HSAG identified no concerns with **DQ**'s methods for assessing network adequacy.

Network Adequacy Indicator Reporting of Results

HSAG assessed **DQ**'s network adequacy indicator reporting processes, and the following summarizes the findings:

- **DQ** maintained data control procedures to ensure accuracy and completeness of data merges from Windward by utilizing QuerySurge to identify variances requiring action. **DQ** also reconciled against **DQ**'s general ledger to ensure data had been captured accurately. **DQ** also performed data mapping in Quest Analytics Suite for both the Enterprise Reporting Multi-Use Directory Report (provider file) and Active Membership Detail Report (membership file).
- **DQ** conducted data reasonability checks on the provider file and membership file by completing month-over-month comparisons against prior member and provider data files, and likewise compared the output against prior reports.
- **DQ** produced network adequacy indicator results using Quest Analytics Suite. **DQ** used Quest Analytics software to geocode member and provider data to convert addresses into geographic coordinates and to process these data into the time and distance metrics required by the State.
- **DQ** maintained network adequacy indicator reports by exporting the reports and storing iterations in a secure folder, according to run date. Multiple **DQ** teams (e.g., Provider Intelligence and Client Engagement) validated network adequacy reports.
- **DQ** conducted data quality checks at multiple points in the network adequacy indicator calculation process to review the accuracy of its reporting programs.
- To ensure continuity of network adequacy indicator production, **DQ** maintained copies of previous reports at a designated path in PDF format, by run date.

HSAG identified no concerns with **DQ**'s network adequacy indicator results or reporting processes.

Assessment of Data Validity

HSAG evaluated and assessed the data methods that **DQ** used to calculate results generated for each network adequacy indicator in scope of NAV. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that **DQ** used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Overall, HSAG determined that the **data collection procedures** in place at **DQ** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that the **network adequacy methods** in place at **DQ** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that **DQ**'s **network adequacy results** were:

☒ Acceptable
☐ Not acceptable

Analytic Findings

HSAG performed independent analyses of **DQ**'s compliance with time and distance and network capacity standards. This section presents the results.

Time and Distance Standards

DHHS has set a minimum threshold of 90 percent for compliance with the time and distance standards, which can be satisfied if the DO meets either the time or distance requirement. This is the first year of activity for **DQ** in New Hampshire, and it met the time or distance standards for 93.3 percent of the dental service types assessed for SFY 2024. Table 2-10 displays the percentage of **DQ**'s members who have the access to care required by contract standards for all applicable dental service types. Red shading indicates the DO did not meet minimum time and distance standards for a specific provider service types.

Table 2-10—Percentage of Members With Required Access to Care by Dental Service Types for DQ

	Percent of Members With Access Within Time or Distance Standards					
	Urban Counties		Middle Counties		Rural Counties	
Type of Service	Time	Distance	Time	Distance	Time	Distance
Dental Diagnostic Services	98.0%	92.6%	100.0%	96.6%	100.0%	100.0%
Dental Preventive Services	98.0%	92.3%	100.0%	96.6%	100.0%	100.0%
Dental Restorative Services	98.0%	92.3%	100.0%	96.6%	100.0%	100.0%

	Percent of Members With Access Within Time or Distance Standards					
	Urban Counties		Middle Counties		Rural Counties	
Type of Service	Time	Distance	Time	Distance	Time	Distance
Dental Oral and Maxillofacial Surgery	99.3%	95.6%	96.4%	77.6%	83.9%	1.6%
Dental Adjunctive General Services	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Note: The time and distance standards vary by urbanicity, taking into account different driving conditions and average expected driving speeds. For example, the standard for oral and maxillofacial surgeons in rural counties is one provider within 120 minutes or 80 miles. In a rural county with average driving speeds of 55 mph, this means that a member could potentially reach a provider 110 miles from their residence in two hours. This sometimes produces fairly large differences in the percentage of members with access using the time standard versus the distance standard. The list of standards is in Appendix A.

Of the 15 time and distance standards that HSAG assessed, **DQ** met the standards for 14 (93.3 percent). Of the five types of dental service types that HSAG assessed, **DQ** met the standards across all three urbanicities for four out of the five service types. **DQ** did not meet the standards for dental oral and maxillofacial surgery in rural counties, although it met the standards for those providers in urban and middle counties.

DQ Validation Ratings

Based on the ISCA results combined with HSAG's analytic validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if the DO's interpretation of data was accurate.

Table 2-11 summarizes HSAG's validation ratings for **DQ**, by indicator type, with **DQ** receiving high confidence for both access and availability and time and distance indicators.

Table 2-11—Summary of DQ Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and Availability (N=44)	100%	0%	0%	0%
Time and Distance (N=15)	100%	0%	0%	0%

Strengths, Opportunities for Improvement, and Recommendations

By assessing **DQ**'s performance and NAV reporting process, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Strengths

Strength #1: DQ had sufficient policies and procedures in place to ensure timeliness and accuracy in data collection and management of data used to inform network adequacy standards and indicators calculation.

Strength #2: DQ met the State's time and distance standards for all five dental service types in urban and middle counties and four of the five service types in rural counties.

Opportunities for Improvement and Recommendations

Opportunity #1: HSAG did not identify any specific opportunities related to the data collection and management processes **DQ** had in place to inform network adequacy standard and indicator calculations.

Recommendation: N/A

Opportunity #2: DQ did not meet the 90 percent time and distance standard for one dental service type, oral maxillofacial surgery, in rural counties.

Recommendation: HSAG recommends that **DQ** maintain current levels of access to care and continue to address network gaps in rural counties for oral maxillofacial surgery.

3. Discussion

Conclusions

While the NAV process may focus on analyzing different aspects of provider networks and members' access to care, this SFY 2024 NAV focused on the ISCA, network capacity and time and distance analyses for specified provider categories using the ISCAT and supporting documentation, as well as member and provider data files that each MCO submitted to HSAG.

The MCEs performed very well. HSAG has high confidence in the MCE-reported data, methods, and results. The time and distance study confirmed that the MCEs met the quantitative standards the State has set for ensuring that the provider networks are adequate in number and location to meet the needs of at least 90 percent of their Medicaid members.

HSAG aligned its SFY 2024 MCO analysis with the reporting template MCOs are required to submit, examining access to several additional provider types for the first time. This is also the first year HSAG analyzed access to a variety of dental service types, due to the addition of a DO which began operation in 2023. All MCEs met the time and distance standards for most of these additional provider and service types, and the results provide a broader understanding of the access to care provided by the MCEs.

Overall the MCEs performed well in the time and distance analysis across all provider types, with three performing above the 90 percent threshold for compliance for the NAV indicators (NHHF 98.4 percent, ACNH 95.0 percent, and DQ 93.3 percent). The final MCE, WS, would likely have scored over the threshold if the provider data it submitted to HSAG had identified providers for several provider types included in its report to DHHS.[4]

All three MCOs provided 100 percent of their members with access to at least two adult and pediatric PCPs within the time and distance standards. All three MCOs surpassed the 90 percent threshold for access to hospitals, psychiatric inpatient care, pharmacies, adult medical daycare, office based physical, occupational and speech therapists, and hospice care, as well as several types of provider assessed for the first time this year including family planning providers, licensed renal dialysis providers, and community mental health centers.

DHHS monitors access to SUD services using both time and distance standards and, for two services, network capacity standards. All three MCOs met the network capacity standards for contracting with 75 percent of the 10 OTP providers identified in DHHS' provider list, in fact contracting with all of the OTP providers. Two of the three MCOs (**NHHF** and **WS**) contracted with 54.2 percent of the listed

[4] The provider file WS submitted to HSAG did not identify providers in about half of the hospital service and diagnostic service provider categories required in the DHHS report (e.g., hospital-maternity, hospital-open heart surgery, or CAT scan providers). During its virtual review, HSAG confirmed that WS was able to identify contracted providers in those categories. Thus, HSAG's analytic results which show several failed standards reflect an omission of data in the file submitted to HSAG rather than gaps in WS's provider network.

residential SUD treatment programs, and **ACNH** contracted with 29.2 percent of those programs. Since the list of SUD programs in DHHS' Network.01 report template does not reflect changes in the provider landscape since 11/07/2022, these results are being considered as informational only, and should be interpreted with caution. However, at least 90 percent of each of the MCO's members had access to at least one residential SUD treatment program within the time and distance standards.

The MCOs have opportunities for improvement related to certain types of pediatric specialists, most notably pediatric ophthalmologists, and to a lesser extent pediatric allergy/immunology specialists and developmental-behavioral pediatricians. The DO could improve by adding oral maxillofacial surgeons in rural counties.

Analytic Considerations

Various factors associated with the SFY 2024 NAV may affect the validity or interpretation of the results presented in this report, including, but not limited to, the following analytic considerations and data-related caveats:

- Time and distance results summarize the geographic distribution of a provider network relative to member residences and may not fully reflect the availability of providers (or appointments) at given office locations. These general statistics do not take into account other issues known to impact access such as whether a specific provider is accepting new Medicaid patients at a specific location or how active the provider is in the Medicaid program.
- When evaluating the results presented in this report, note that provider data which the health plans supplied may not include providers contracted with the health plans under limited use contracts or single case agreements.
- DHHS recognizes that some of the provider lists developed for its network capacity standards report template do not reflect changes in the provider landscape after November 7, 2022. The MCOs submitted data from a later time period; and NPI, provider name, and address discrepancies made it difficult for HSAG to identify reliable matches between the lists and the plan data. Although HSAG was able to find reliable matches between the provider data and the list of OTP providers, HSAG found it more difficult to find reliable matches with the list of SUD residential providers. At best, two MCOs were able to contract with only slightly over 50 percent of the listed providers, and they presented evidence that called into question whether those providers are still practicing in New Hampshire. DHHS should continue to consider working toward a more objective and timely method for identifying the denominator for this indicator in future reports. DHHS has asked the MCOs to report their results as requested in the template; however, users of this report should consider the results as informational only and interpret them with caution due to known issues with defining the denominators.

Statewide Recommendations

- DHHS' network capacity standards for SUD provider types require the MCOs to contract with a minimum percentage of four types of SUD providers or programs licensed and practicing in the state.[5] DHHS prepopulates a list of relevant providers in its template for the Network.01 report, to be completed by the MCOs. HSAG recommends that DHHS update that provider list on at least an annual basis to support a timely, and more meaningful assessment of the capacity of the MCOs' networks to provide these services.
- DHHS should continue to review provider categories for which MCEs did not meet the geographic access standards, with the goal of determining whether or not the MCEs' failure to meet the standard(s) was the result of a lack of providers, lack of providers willing to contract with Medicaid, or simply providers unwilling to contract with a given MCE. Future analyses could also evaluate the extent to which the MCEs have requested exemptions from DHHS for provider categories for which providers may not be available or willing to contract with the MCEs and DHHS' disposition of those requests.
- DHHS should continue to work with HSAG and the MCEs to improve the quality of reported data. DHHS could encourage MCEs to carefully distinguish between individual and organizational or facility records for provider types that include both individual and organizational or facility providers. For example, HSAG did not accept an MCO's listing of an individual physician as meeting the standard for access to an SUD residential treatment facility.
- In addition to assessing the number, distribution, and availability of providers, DHHS may consider reviewing patient satisfaction survey results and grievance and appeal data to evaluate the degree to which members are satisfied with their access to providers.
- HSAG recommends that the MCEs continue to monitor member access through network adequacy assessments based on the State's expectations.

[5] The SUD providers governed by the network adequacy standards are buprenorphine prescribers, master licensed alcohol and drug counselors (MLADCs), opioid treatment providers (OTPs), and residential SUD treatment programs. Per guidance from DHHS, HSAG only calculated results for OTPs and residential SUD treatment programs during SFY 2024.

Appendix A. Network Adequacy Standards

DHHS' quantitative standards for network adequacy are found in its managed care contracts and listed in regular provider network reports submitted by the MCEs via templates provided by DHHS. DHHS provided HSAG with specifications for these reports as well as copies of communications regarding the intent behind the standards that occurred between DHHS and the MCEs.

MCO Network Adequacy Standards

For the MCOs, network adequacy standards include maximum travel time or distance to providers, minimum network capacity standards, and timely access (or appointment availability) standards as described below. Note that HSAG did not conduct an independent analysis of compliance with the timely access standards, but HSAG did assess the MCOs' data, methodologies, and reporting processes as part of the ISCA findings and provided the results with validation scores.

Time and Distance

DHHS requires MCOs to submit provider network reports annually and on an ad hoc basis using DHHS report templates. Table A-1 presents the maximum time and distance standards for all provider categories required to report for network adequacy validation.

Table A-1—MCO Provider Time or Distance Standards

Provider Category	Standard[1]
Adult Primary Care (PCP)	At least 90 percent of members must have access to two adult primary care providers (2) within 40 minutes or 15 miles of their residence
Adult Medical Daycare	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Hospice	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Allergist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Audiology	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Cardiologist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
CAT Scan Provider	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Child Primary Care	At least 90 percent of members must have two (2) within forty (40) minutes or fifteen (15) miles

Provider Category	Standard[1]
Community Mental Health Center	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Developmental-Behavioral Pediatrician	At least 90 percent of members must have one (1) within forty-five (45) minutes or twenty-five (25) miles
Durable Medical Equipment (DME)	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Family Planning	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
General Inpatient Psychiatric	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
General Surgeon	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Hospice	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Hospital—Diagnostic Cardiac Catheterization	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Hospital—General Acute Care	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Hospital—Level 1 Major Trauma Treatment	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Hospital—Level 3/4 Neonatal Intensive Care	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Hospital—Maternity	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Hospital—Open-Heart Surgery Services	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Hospital—Therapeutic Radiation	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Imaging Provider (Ultrasound & X-Ray) Provider	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Laboratory	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Licensed Renal Dialysis Provider	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Magnetic Resonance Imaging Center	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Methadone Clinics	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles

Provider Category	Standard[1]
Neurologist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Obstetrician/Gynecologist or Other Maternity Provider	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Oncologist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Optometrist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Ophthalmologist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Orthopedist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Otolaryngologist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Pediatric Allergist/Immunologist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Audiologist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Cardiologist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Dermatologist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Endocrinologist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Gastroenterologist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Neurologist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Ophthalmologist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Orthopedic Surgeon	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Orthopedist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Otolaryngologist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Plastic Surgeon	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles

Provider Category	Standard[1]
Pediatric Psychiatrist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pediatric Urologist	At least 90 percent of members must have one (1) within one hundred twenty (120) minutes or eighty (80) miles
Pharmacy	At least 90 percent of members must have one (1) within forty-five (45) minutes or fifteen (15) miles
Office Based Physical Therapist/Occupational Therapist/Speech Therapist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Plastic Surgeon	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Podiatry	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Psychiatrist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Psychologist	At least 90 percent of members must have one (1) within forty-five (45) minutes or twenty-five (25) miles
Short Term Care Facility for Involuntary Psychiatric Admissions	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Hospital/Short Term Facility For Inpatient Medical Rehabilitation Services	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
SUD Comprehensive Program	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
SUD Master Licensed Alcohol & Drug Counselor	At least 90 percent of members must have one (1) within forty-five (45) minutes or fifteen (15) miles
SUD Outpatient Program	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Thoracic Surgeon	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Urologist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles

[1] The table presents time and distance standards in minutes of driving time and miles of driving distance. MCEs need only meet one or the other.

Network Capacity Standards

DHHS has set network capacity standards for two SUD provider types, requiring that each MCE contract with a specified percentage of all such providers licensed and practicing in New Hampshire.

Table A-2—MCO Network Capacity Standards

Provider Type	Standard
Opioid (Methadone) Treatment Providers (OTP)	MCO must contract with at least 75 percent of opioid treatment providers licensed and practicing in the state.
Residential Substance Use Disorder Treatment Programs	MCO must contract with at least 50 percent of Residential Substance Use Disorder Treatment Programs licensed and practicing in the state

Access and Availability (Timely Access) Standards

DHHS has set timely access standards for MCOs and requires that the MCOs conduct annual surveys and activities to assess whether members have access to care within reasonable time limits. Table A-3 provides the network timely access standards applicable to MCOs. The standards vary by provider category, as indicated.

Table A-3—MCO Timely Access Standards With Percentage Thresholds by Provider Type

Standard	PCPs	Adult Specialist	Pediatric Specialist	MH Providers Adult	MH Providers Pediatric	SUD Counselor	SUD Programs
The percentage of providers that make services available for members 24 hours a day and 7 days a week when medically necessary	80%	50%	75%	90%	90%	90%	90%
The percentage of providers that offer hours of operation for Medicaid members that are no less than the hours offered to commercial or Medicaid FFS enrollees	100%	100%	100%	100%	100%	100%	100%
The percentage of PCPs that offer after-hours office care in the evenings	N/A	N/A	N/A	N/A	N/A	N/A	N/A
The percentage of PCPs that offer after-hours office care on weekends	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Standard	PCPs	Adult Specialist	Pediatric Specialist	MH Providers Adult	MH Providers Pediatric	SUD Counselor	SUD Programs
The percentage of providers that offer appointments to Medicaid members for non-symptomatic (i.e., preventive care) office visits within 45 calendar days	90%	50%	75%	N/A	N/A	N/A	N/A
The percentage of providers that offer appointments to standard Medicaid members for non-urgent, symptomatic (i.e., routine care) visits within 10 days (business days for behavioral health and calendar days for non-behavioral health)	100%	70%	70%	60%	60%	80%	80%
The percentage of providers that offer appointments for Medicaid members for urgent, symptomatic conditions within 48 hours	100%	70%	70%	60%	60%	60%	60%
The percentage of behavioral health providers that offer care within six hours for a non-life threatening emergency	N/A	N/A	N/A	40%	40%	40%	40%
The percentage of providers that provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities	100%	100%	100%	100%	100%	100%	100%

DO Network Adequacy Standards

Time and Distance

DHHS requires the DO to submit provider network reports monthly through March 2024, and quarterly thereafter (July 2024, October 2024, January 2025, and April 2025) using the report template that DHHS provided. Table A-4 presents the maximum time and distance standards for all dental service reporting categories. Standards differ by type of dental services rather than by type of dental provider, with the allowed time or distance varying by whether a member resides in an urban, middle, or rural county as defined by DHHS.

Table A-4—DO Time or Distance Standards by Dental Service Type and Urbanicity[1]

Service/Provider Type	Standard for Urban Counties	Standard for Middle Counties	Standard for Rural Counties
Dental Diagnostic Services	At least 90 percent of members must have one (1) within fifteen (15) minutes or ten (10) miles	At least 90 percent of members must have one (1) within forty (40) minutes or twenty (20) miles	At least 90 percent of members must have one (1) within sixty (60) minutes or thirty (30) miles
Dental Preventive Services	At least 90 percent of members must have one (1) within fifteen (15) minutes or ten (10) miles	At least 90 percent of members must have one (1) within forty (40) minutes or twenty (20) miles	At least 90 percent of members must have one (1) within sixty (60) minutes or thirty (30) miles
Dental Restorative Services	At least 90 percent of members must have one (1) within fifteen (15) minutes or ten (10) miles	At least 90 percent of members must have one (1) within forty (40) minutes or twenty (20) miles	At least 90 percent of members must have one (1) within sixty (60) minutes or thirty (30) miles
Dental Oral and Maxillofacial surgery	At least 90 percent of members must have one (1) within thirty (30) minutes or twenty (20) miles	At least 90 percent of members must have one (1) within eighty (80) minutes or forty (40) miles	At least 90 percent of members must have one (1) within one hundred and twenty (120) minutes or eighty (80) miles
Dental Periodontics	N/A	N/A	N/A
Dental Prosthodontics	N/A	N/A	N/A
Dental Adjunctive General Services	At least 90 percent of members must have one (1) within thirty (30) minutes or twenty (20) miles	At least 90 percent of members must have one (1) within eighty (80) minutes or forty (40) miles	At least 90 percent of members must have one (1) within one hundred and twenty (120) minutes or eighty (80) miles

[1] The table presents time and distance standards in minutes of driving time and miles of driving distance. DHHS requires that 90 percent of adult members have access to at least one provider of specified dental services within the driving time or distance standard across all dental service types and county classifications.

Access and Availability (Timely Access) Standards

Table A-5 provides the network timely access standards applicable to the DO. The table describes the related standards, with the applicable thresholds, which vary according to whether a provider is a primary dental provider or a dental specialist.

Table A-5—DO Timely Access Standards With Percentage Thresholds by Provider Type[1]

Standard	Threshold for Primary Dental Providers	Threshold for Dental Specialists
The percentage of dental providers making services available for members 24 hours a day and 7 days a week when medically necessary	80%	50%
The percentage of dental providers offering hours of operation for Medicaid members that are no less than the hours offered to commercial or Medicaid FFS enrollees	100%	100%
The percentage of dental providers offering appointments to Medicaid members for non-symptomatic (i.e., preventive care) office visits within 45 calendar days	90%	50%
The percentage of dental providers offering appointments to standard Medicaid members for non-urgent, symptomatic (i.e., routine care) visits within 10 days	100%	70%
The percentage of dental providers offering appointments for Medicaid members for urgent, symptomatic conditions within 48 hours	100%	70%
The percentage of dental providers providing physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities	100%	100%

[1] Primary dental providers are general dentists. Dental specialists for purposes of these standards are dentists who have a specialty of oral and maxillofacial surgery. Unlike the time and distance standards, the timely access standards are the same across all urbanicities.

Appendix B. Methodology

Appendix B describes the DHHS-approved methodology for the SFY 2024 NAV activities, including HSAG's NAV analysis and its ISCA-specific methodology and activities.

ISCA Methodology

Validation of network adequacy consists of several activities that fall into three phases of activities: (1) planning, (2) analysis, and (3) reporting, as outlined in the CMS EQR Protocol 4. To complete validation activities for the MCEs, HSAG obtained all DHHS-defined network adequacy standards and indicators that DHHS requires for validation.

HSAG prepared and submitted a document request packet to each MCE outlining the activities that HSAG conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess the MCEs' information systems and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Documents that HSAG requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCEs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained data and documentation from the MCEs, such as network data files or directories and member enrollment files, through a single documentation request packet that HSAG provided to each MCE.

HSAG hosted an MCE-wide webinar focused on providing technical assistance to the MCEs to develop a greater understanding of all activities associated with NAV, standards/indicators in the scope of validation, helpful tips on how to complete the ISCAT, and a detailed review of expected deliverables with associated timelines.

HSAG conducted validation activities via interactive virtual review, which this report refers to as "virtual review," as these activities are the same in both virtual and on-site formats.

Technical Methods of Data Collection and Analysis

The CMS EQR Protocol 4 identifies key activities and data sources needed for NAV. The following list describes the types of data collected and how HSAG conducted an analysis of these data:

- **Information systems underlying network adequacy monitoring**: HSAG conducted an ISCA by using each MCE's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the MCE tracks providers over time, across multiple office locations, and through changes in participation in the MCE's network. HSAG used the ISCAT to assess the ability of the MCE's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the MCE's IT system architecture, file structure, information flow, data processing procedures, and

completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

- **Validate network adequacy logic for calculation of network adequacy indicators**: HSAG required each MCE that calculated the DHHS-defined indicators to submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG identified whether the required variables were in alignment with the DHHS-defined indicators used to produce the MCE's indicator calculations. HSAG required each MCE that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps the MCE took for indicator calculation.
- **Validate network adequacy data and methods**: HSAG assessed data and documentation from MCEs that included, but was not limited to, network data files or directories, member enrollment data files, and appointment availability surveys. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness.
- **Validate network adequacy results**: HSAG assessed the MCE's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCE and DHHS network adequacy monitoring results. HSAG validated network adequacy reporting against DHHS-defined indicators. HSAG assessed whether the results were valid, accurate, and reliable, and if the MCE's interpretation of the data was accurate.
- **Supporting documentation**: HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Virtual Review Validation Activities

HSAG conducted a virtual review with each MCE. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities are described below:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key MCE staff members involved in the NAV activities, the review purpose, the required documentation, basic meeting logistics, and organization overview.
- **Review of the ISCAT and supporting documentation:** HSAG designed this session to be interactive with key MCE staff members so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and understand systems and processes for maintaining and updating provider data and assessing the MCE's information systems required for NAV. HSAG conducted interviews to confirm findings from the documentation review, expanded or

clarified outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.

- **Evaluation of underlying systems and processes:** HSAG evaluated the MCE's information systems, focusing on the MCE's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; MCE oversight of external information systems, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key staff members familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff members included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors, and other front-line staff members familiar with network adequacy monitoring and reporting activities. Appendix D lists the MCE interviewees.
- **Overview of data collection, integration, methods, and control procedures:** The overview included discussion and observation of methods and logic used to calculate each network adequacy indicator. HSAG evaluated the integration and validation process across all source data and how the MCE produced the analytics files to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures during this session.

Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated each MCE's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCE and DHHS network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCE used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table B-1.

Table B-1—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Score = A / (A + B) x 100
Number of *Not Met* elements determined to have significant bias on the results.

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that the

MCE used acceptable methodology for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, as shown in Table B-2. HSAG assigns a rating once it has calculated the validation score for each indicator.

Table B-2—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	High Confidence
50.0% to 89.9%	Moderate Confidence
10.0% to 49.9%	Low confidence
Less than 10% and/or any *Not Met* element has significant bias on the results	No Confidence

Table B-3 and Table B-4 present sample validation rating determinations. Table B-3 presents an example of a validation rating determination based solely on the validation score, as there were no *Not Met* elements that were determined to have significant bias on the results, whereas Table B-4 presents an example of a validation rating determination that includes a *Not Met* element that had significant bias on the results.

Table B-3—Example Validation Rating Determination—No Significant Bias

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of *Met* elements	16	Moderate Confidence
B. Total number of *Not Met* elements	3	
Validation Score = A / (A + B) x 100%	84.2%	
Number of *Not Met* elements determined to have significant bias on the results	0	

Table B-4—Example Validation Rating Determination—Includes Significant Bias

Worksheet 4.6 Summary	Worksheet 4.6 Result	Validation Rating Determination
A. Total number of *Met* elements	15	No Confidence
B. Total number of *Not Met* elements	4	
Validation Score = A / (A + B) x 100%	78.9%	
Number of *Not Met* elements determined to have significant bias on the results	1	

HSAG determined significant bias based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the MCE provide a root cause analysis of the finding.
- Working with the MCE to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- HSAG's NAV Oversight Review Committee reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact to determine the degree of bias.
- HSAG's NAV Oversight Review Committee finalizing a bias determination based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or HSAG was unable to quantify the impact and therefore determined the potential for significant bias.

NAV Methodology

Technical Methods of Data Collection and Analysis

To conduct the NAV analysis, HSAG requested data from DHHS and the MCEs.

Member Data

HSAG requested Medicaid member files from DHHS and from each MCE. HSAG submitted a detailed member data requirements document to DHHS and the MCEs and allowed for a technical assistance call to review the data request in detail and clarify any questions regarding the data request. HSAG requested data for members actively enrolled in an MCE as of December 31, 2023, including these key data elements: member's street address, city, state, ZIP Code, date of birth, dates of enrollment, and MCE affiliation.

Provider Data

HSAG requested Medicaid provider files from DHHS reflecting all providers enrolled in the State's Medicaid program. From the MCEs, HSAG requested provider files reflecting all active providers serving its Medicaid members. HSAG requested the following key data elements: provider name, NPI, address, provider type, specialty, taxonomy codes, and New Hampshire Medicaid provider type codes, if available.

MCE Provider Network Reports

Table B-5 lists the annual and ad hoc network adequacy reports and data that the MCEs submitted to DHHS, along with their respective reporting dates. HSAG requested these reports from both the MCEs and DHHS.

Table B-5—Required Network Reports and Reporting Periods

Report Name and Entity Submitting	Report Frequency	Template	Data Period	Date Submitted to DHHS
MCOs				
Comprehensive Provider Network and Equal and Timely Access Annual Filing	Annual	Network.01_2021.5.4	1/1/2023–12/31/2023	2/14/2024
Corrective Action Plan to Restore Provider Network Adequacy: Annual Template	Annual, and ad hoc if necessary	Network.10_2021.5.26	1/1/2023–12/31/2023	2/14/2024
Access to Care Provider Survey	Annual	Network.11_2021.09.01	7/1/2022–6/30/2023	8/14/2023
DO				
Comprehensive Dental Provider Network and Equal and Timely Access Annual Filing[1]	Annual, and monthly	2023.08.22 DENTAL_Network.01	2/1/2024–2/29/2024	4/12/2024
Corrective Action Plan to Restore Dental Provider Network Adequacy	Ad hoc if necessary	DENTAL_Network.02	As applicable	45 days after end of measurement period
Access to Dental Care Provider Survey	Annual	DENTAL_Network.03	4/1/2023–3/31/2024	5/15/2024

[1] The Dental Annual Network report covers the data period of April 1, 2023, through June 30, 2024. However, the DO is currently conducting monthly network reporting during this first year of the contract, which commenced in April 2023. For this analysis, HSAG used the monthly file covering February 2024.

Methods of Analysis and How Conclusions Were Drawn

Time and Distance

For each MCE, HSAG calculated the percentage of members with required access according to the time and distance standards, and evaluated whether 90 percent of members met either the time or distance

standard. HSAG used Quest Analytics software to calculate the travel time and physical distance between the addresses of specific members for all provider categories identified in the analysis. HSAG also visually compared its results to MCE-submitted results included in the Network.01 and Dental Network.01 reports for general consistency and reasonability.

Network Capacity

For the two SUD provider types evaluated in this study, HSAG compared provider MCE-submitted data files to the SUD provider lists contained in the Network.01 template worksheet, SUD Provider Net, as shown in Table B-6. For each provider listed in the SUD Provider Net worksheet in the Network.01 report, HSAG assessed the extent to which every MCE-submitted provider record matched the listed provider information. For each listed provider and each submitted provider record, HSAG calculated a matching score based on provider category (ProvCat), NPI, provider name, street address, street name, city, and ZIP Code. HSAG sought exact matches on ProvCat, NPI, city, and ZIP Code, and also identified "fuzzy" (approximate) matches for provider name, street address, and street name. HSAG gave NPI substantial weight in the assessment, while HSAG gave ProvCat and fuzzy matches reduced weight. For each listed provider, HSAG identified the submitted provider record most closely resembling the listed provider and determined whether it should consider the submitted record a match. HSAG refined the algorithm making this determination to work around issues in the source data, such as missing NPI or missing address components in the SUD Provider Net list. HSAG reviewed these determinations and in a small number of instances reversed them based on detailed review.

Table B-6—MCE Provider Capacity Standards

Provider Type/Service	Requirement
Opioid Treatment Programs (OTPs)	The MCO Participating Provider Network shall include seventy-five percent (75%) of the OTP providers licensed and practicing in New Hampshire, as set out in the Network.01 2021.5.4 template, Tab C, SUD Provider Net.
Residential SUD Treatment Programs	The MCO Participating Provider Network shall include fifty percent (50%) of all such providers licensed and practicing in New Hampshire, as set out in the Network.01 2021.5.4 template, Tab C, SUD Provider Net.

Appendix C. MCO Statewide Comparative Results

Appendix C presents tables with comparative results across MCOs for time and distance standards and network capacity standards.

Statewide Time and Distance Results by MCO

Table C-1 displays the percentage of each MCO's members who had the access to care required by contract standards for all applicable provider categories, by MCO. Red shading indicates that the MCO did not meet minimum time and distance standards for a specific provider category.

Table C-1—Percentage of Members With Required Access to Care by Provider Category and MCO

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Primary Care							
Primary Care, Adult	Adults	100.0%	99.9%	100.0%	99.9%	100.0%	>99.9%
Primary Care, Pediatric	Children and adolescents	100.0%	>99.9%	100.0%	99.9%	100.0%	97.7%
Physician Specialists							
Allergist, Adult	Adults	99.9%	98.1%	99.9%	97.6%	95.1%	93.4%
Allergist/Immunologist, Pediatric[1]	Children and adolescents	81.7%	79.0%	98.8%	87.3%	78.0%	71.8%
Audiologist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Audiologist, Pediatric	Children and adolescents	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Cardiologist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cardiologist, Pediatric[1]	Children and adolescents	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist, Pediatric[1]	Children and adolescents	100.0%	98.0%	>99.9%	97.2%	>99.9%	98.0%
Endocrinologist, Pediatric[1]	Children and adolescents	100.0%	99.5%	>99.9%	97.2%	>99.9%	99.3%
Gastroenterologist, Pediatric[1]	Children and adolescents	100.0%	99.5%	>99.9%	97.2%	>99.9%	98.2%
General Surgeon	All members	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%
Neurologist, Pediatric[1]	Children and adolescents	100.0%	99.4%	>99.9%	97.2%	>99.9%	99.3%
Obstetrician/Gynecologist or Other Maternity Provider	Females, ages 13 and older	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%
Oncologist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	99.9%	99.6%
Ophthalmologist, Adult	Adults	97.6%	95.6%	99.9%	99.2%	99.9%	99.5%
Ophthalmologist, Pediatric[1]	Children and adolescents	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Optometrist	All members	99.9%	99.6%	100.0%	100.0%	100.0%	100.0%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Orthopedic Surgeon, Pediatric[1]	Children and adolescents	100.0%	98.0%	99.9%	70.1%	0.0%	0.0%
Orthopedist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist, Pediatric	Children and adolescents	100.0%	98.0%	100.0%	100.0%	0.0%	0.0%
Otolaryngologist, Adult	Adults	100.0%	>99.9%	100.0%	>99.9%	100.0%	>99.9%
Otolaryngologist, Pediatric[1]	Children and adolescents	100.0%	98.0%	>99.9%	97.2%	92.2%	81.6%
Pediatrician, Developmental-Behavioral[1]	Children and adolescents	74.2%	53.0%	91.6%	78.1%	71.3%	49.2%
Plastic Surgeon, Adult	Adults	93.4%	91.7%	99.6%	98.7%	93.0%	91.4%
Plastic Surgeon, Pediatric	Children and adolescents	100.0%	98.0%	100.0%	100.0%	0.0%	0.0%
Podiatry, Adult	Adults	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%
Psychiatrist, Adult	Adults	100.0%	100.0%	100.0%	100.0%	99.8%	98.9%
Psychiatrist, Pediatric	Children and adolescents	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%
Psychologist	All members	100.0%	99.4%	100.0%	99.8%	99.8%	97.2%
Thoracic Surgeon, Adult	Adults	95.8%	93.7%	94.6%	94.1%	95.7%	94.8%
Urologist, Adult	Adults	100.0%	100.0%	100.0%	>99.9%	100.0%	100.0%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Urologist, Pediatric[1]	Children and adolescents	100.0%	98.6%	>99.9%	97.2%	>99.9%	98.0%
Hospital Services							
Hospital—General Acute Care	All members	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospital—Maternity[2]	Females, ages 13 and older	100.0%	>99.9%	99.9%	99.2%	0.0%	0.0%
Hospital—Level 3/4 Neonatal Intensive Care[2]	All members	100.0%	98.1%	>99.9%	97.2%	0.0%	0.0%
Hospital—Level 1 Major Trauma Treatment[2]	All members	100.0%	98.1%	100.0%	100.0%	0.0%	0.0%
Hospital—Diagnostic Cardiac Catheterization[2]	All members	98.6%	97.3%	98.0%	95.0%	0.0%	0.0%
Hospital—Open-Heart Surgery Services[2]	All members	100.0%	98.0%	>99.9%	97.2%	0.0%	0.0%
Hospital—Therapeutic Radiation	All members	95.7%	93.7%	93.2%	91.7%	66.0%	59.4%
Hospital/Short Term Facility For Inpatient Medical Rehabilitation Services	All members	100.0%	100.0%	100.0%	99.6%	94.7%	92.3%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Short Term Care Facility for Involuntary Psychiatric Admissions[2]	All members	95.1%	93.2%	93.4%	91.6%	0.0%	0.0%
General Inpatient Psychiatric	All members	99.2%	96.4%	98.8%	96.3%	99.9%	97.3%
Diagnostic Services							
CAT Scan Provider[2]	All members	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Imaging Provider (Ultrasound & X-Ray) Provider	All members	100.0%	100.0%	100.0%	100.0%	39.3%	29.5%
Magnetic Resonance Imaging Center	All members	100.0%	100.0%	100.0%	100.0%	94.6%	93.2%
Laboratory	All members	100.0%	100.0%	100.0%	100.0%	84.6%	88.0%
Other Facilities and Services							
Pharmacy	All members	100.0%	99.6%	100.0%	99.4%	100.0%	99.6%
Durable Medical Equipment (DME)	All members	99.6%	97.9%	100.0%	>99.9%	>99.9%	99.8%
Adult Medical Daycare	Adults	99.5%	96.0%	98.6%	93.2%	99.2%	93.9%
Family Planning	All members, ages 13 and older	100.0%	100.0%	100.0%	100.0%	98.1%	95.9%
Licensed Renal Dialysis Provider	All members	98.8%	96.1%	100.0%	>99.9%	100.0%	>99.9%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Office Based Physical Therapist/Occupational Therapist/Speech Therapist	All members	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Community Mental Health Center	All members	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospice	Adults	99.9%	99.6%	100.0%	>99.9%	99.9%	99.5%
Hospice	All members	99.9%	99.6%	100.0%	>99.9%	>99.9%	99.6%
Substance Use Disorder (SUD) Services							
SUD Master Licensed Alcohol & Drug Counselor	All members	100.0%	98.5%	99.3%	92.5%	99.9%	94.4%
Methadone Clinics	All members	95.2%	93.8%	98.8%	95.2%	95.2%	93.8%
SUD Comprehensive Program	All members	>99.9%	99.8%	99.9%	99.5%	95.1%	93.9%
SUD Outpatient Program	All members	100.0%	>99.9%	100.0%	99.9%	98.2%	97.5%

[1] DHHS identified these specialists with taxonomy codes, which **WS** did not use.

[2] Data that **WS** submitted to HSAG did not include providers of these services, but the report that **WS** submitted to DHHS did include them.

Statewide Network Capacity Analysis Results by MCO

Table C-2 displays the statewide network capacity analysis results for OTPs (i.e., the percentage of providers licensed and practicing in New Hampshire).

Table C-2—Statewide Network Capacity Analysis Results for OTPs by MCO

MCO	Standard	Percent of Providers in the State
ACNH	75% of 10 listed providers	100.0%
NHHF	75% of 10 listed providers	100.0%
WS	75% of 10 listed providers	100.0%

Table C-3 displays the statewide network capacity analysis results for residential SUD treatment programs (i.e., the percentage of providers or programs licensed and practicing in New Hampshire). These results should be considered for information only and interpreted with caution.

Table C-3—Statewide Network Capacity Analysis Results for Residential SUD Treatment Programs by MCO

MCO	Standard	Percent of Providers in the State
ACNH	50% of 24 listed programs	29.2%
NHHF	50% of 24 listed programs	54.2%
WS	50% of 24 listed programs	54.2%

Appendix D. HSAG Validation Team and List of Interviewees

Appendix D contains a list of the MCE interviewees who attended the virtual review sessions as well as HSAG interviewing staff.

Table D-1 lists the **ACNH** staff members whom the HSAG validation team interviewed.

Table D-1—List of ACNH Interviewees

Interviewee Name	Title
James Mancuso	Regulatory Reporting Manager
Lisa Pettengill	Director of Compliance
Nancy Bevens	Director of Provider Network Operations
Jarrod Barshinger	Senior Analyst, Plan Analytics
Derrick Carswell	Manager, Advanced Analytics
Roland Stone	Director, Provider Network Management
Anita Gregoire	Manager, Provider Enrollment Services

Table D-2 lists the **NHHF** staff members whom the HSAG validation team interviewed.

Table D-2—List of NHHF Interviewees

Interviewee Name	Title
Judy Tasker	Senior Director, Provider Network Operations
Angela Clement	Senior Reports and Data Specialist
Amy Foye	Senior Manager, Operations
Jane K. Kapoian	Senior Director, Claims Operations

Table D-3 lists the **WS** staff members whom the HSAG validation team interviewed.

Table D-3—List of WS Interviewees

Interviewee Name	Title
Allison Deptula	Medicaid Program Operations Manager
Janae Hagel	Project Coordinator
Kim Trvalik	Behavioral Health (BH) Program Director
Kelli Accardi	BH Program Manager
Sarah Tallman	Manager of BH Program Operations

Interviewee Name	Title
Archie Hamilton	BH Operations Business Manager
Jessica Ollila	Senior Account Service Manager
Lisdunia Sanchez	Account Service Manager
Jessica Caron	Account Executive
Sugeylis Urbaez	Provider Network Senior Manager
Michael Comerford	Director, Medicare and Medicaid Compliance
Holly Eaton	Director of Contracting and Provider Engagement

Table D-4 lists the **DQ** staff members whom the HSAG validation team interviewed.

Table D-4—List of DQ Interviewees

Interviewee Name	Title
Liza Morris	Associate Director, Provider Operations
Brian Mayer	Director, Quality Oversight
Diana Flood	Director, Compliance
Jason Carothers	Lead Engineer
Nicole Mantanye	Director, Provider Network Intelligence
Talia Rodgers	Senior Manager, Business Analytics
Pat Whelan	Senior Client Partner
Tracy Gilman	Director, Government Programs, Northeast Delta Dental

Table D-5 lists the HSAG validation team members, their roles, and their skills and expertise.

Table D-5—HSAG Validation Team

Name and Title	Role
Elisabeth Hunt, MHA, CHCA *Executive Director, Data Science & Advanced Analytics (DSAA)*	Certified Healthcare Effectiveness Data and Information Set (HEDIS®)[D-1] Compliance Auditor (CHCA); multiple years of auditing experience with expertise in data integration, information systems, provider data, network adequacy validation, and performance measure development and reporting.
Rachael French, CHCA *Associate Director, Audits, DSAA*	CHCA; multiple years of auditing experience with expertise in managed care, quality measure reporting, quality improvement (QI), performance measure knowledge, data integration, systems review, and analysis, provider data, and network adequacy source data and validation.

[D-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Name and Title	Role
Cynthia Anderson, MPH *Analytics Manager III, DSAA* *Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review, network adequacy, and analysis.
Janice Brown *Auditor III, DSAA* *Secondary Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review, network adequacy, and analysis.
Leslie Arendell, MS *Director, DSAA* *NAV Auditor*	Subject matter expertise in network adequacy, data analysis, Medicaid managed care, provider network data and validation, QI, and member eligibility/enrollment data. Analytics auditor for SFY 2024 **NHHF** and **WS** ISCA virtual review
Cindy Strickland *Associate Director, DSAA* *NAV Auditor*	Subject matter expertise in network adequacy data, analysis, and reporting. Task lead for New Hampshire NAV activities since SFY 2023, and analytics auditor for SFY 2024 **ACNH** ISCA virtual review.
Ashling Whelan *Analytics Manager, Associate; DSAA* *NAV Auditor*	Subject matter expertise in network adequacy data, analysis, and reporting. Analytics auditor for SFY 2024 **DQ** ISCA virtual review.

Appendix E. MCE Recommendations Requiring Follow-Up

The following MCE-specific sections show how the MCEs will address and DHHS will monitor each of HSAG's recommendations pertinent to the MCEs.

ACNH

Table E-1 lists opportunities for improvement to include in the quality assessment and performance improvement report for **ACNH**.

Table E-1—EQRO Findings and Recommendations for Improvement From the NAV Report to Include in the EQRO.01 Report for ACNH

ACNH EQRO Findings/Recommendations for Improvement to Include in the EQRO.01 Report		
NAV Report		
1	ACNH-2024-EQRO.01_NA-01	**ACNH** did not meet the 90 percent time and distance standards for three provider categories: pediatric allergists/immunologists, developmental-behavioral pediatrician specialists, and pediatric ophthalmologists. **Recommendation:** HSAG recommends that **ACNH** maintain current levels of access to care and continue to address network gaps for the following provider categories: pediatric allergists/immunologists, developmental-behavioral pediatrician specialists and pediatric ophthalmologists.

NHHF

Table E-2 lists opportunities for improvement to include in the quality assessment and performance improvement report for **NHHF**.

Table E-2—EQRO Findings and Recommendations for Improvement From the NAV Report to Include in the EQRO.01 Report for NHHF

NHHF EQRO Findings/Recommendations for Improvement to Include in the EQRO.01 Report		
NAV Report		
1	NHHF-2024-EQRO.01_NA-01	HSAG observed that **NHHF** had minimal programmer staff trained and capable of supporting network adequacy data analysis and oversight of contracted vendors performing network adequacy calculations. **Recommendation:** HSAG recommends that **NHHF** enhance its vendor oversight to ensure vendors are knowledgeable and can support network adequacy analyses, and

NHHF EQRO Findings/Recommendations for Improvement to Include in the EQRO.01 Report		
NAV Report		
		consider cross-training **NHHF** staff to increase internal knowledge and capabilities to support ongoing network adequacy data monitoring.
2	NHHF-2024-EQRO.01_NA-02	**NHHF** did not meet the 90 percent time and distance standard for one provider category, pediatric ophthalmologist. **Recommendation:** HSAG recommends that **NHHF** maintain the current level of access to care and continue to address network gaps for pediatric ophthalmologists.

WS

Table E-3 lists opportunities for improvement to include in the quality assessment and performance improvement report for **WS**.

Table E-3—EQRO Findings and Recommendations for Improvement From the NAV Report to Include in the EQRO.01 Report for WS

WS EQRO Findings/Recommendations for Improvement to Include in the EQRO.01 Report		
NAV Report		
1	WS-2024-EQRO.01_NA-01	**WS** did not meet the 90 percent time and distance standards for several pediatric specialists. HSAG learned during the virtual review sessions that WS did not track taxonomy codes as DHHS recommended in its crosswalk. Instead, the MCO identified and reported providers who specialize in certain general areas (e.g. orthopedic surgery) and accept children as patients. **Recommendation:** HSAG recommends that **WS** maintain current levels of access to care and continue to address network gaps for the following provider categories: pediatric allergist/immunologist, audiologist, orthopedic surgeon, orthopedist, and plastic surgeon, as well as developmental-behavioral pediatricians. WS should also consider collecting and using taxonomy codes in accordance with DHHS standards.

DQ

Table E-4 lists opportunities for improvement to include in the quality assessment and performance improvement report for **DQ**.

Table E-4—EQRO Findings and Recommendations for Improvement From the NAV Report to Include in the DENTAL_EQRO.01 Report for DQ

DQ EQRO Findings/Recommendations for Improvement to Include in the DENTAL_EQRO.01 Report		
NAV Report		
1	DQ-2024-DENTAL_EQRO.01_NA-01	**DQ** did not meet the 90 percent time and distance standard for one dental service type, oral maxillofacial surgery, in rural counties. **Recommendation:** HSAG recommends that **DQ** maintain current levels of access to care and continue to address network gaps in rural counties for oral maxillofacial surgery.