State of New Hampshire Department of Health and Human Services

State Fiscal Year 2023 Network Adequacy Validation Report

August 2023

—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) 2023 network adequacy validation (NAV) has a conflict of interest with the following MCOs: **AmeriHealth Caritas New Hampshire, Inc.** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), and **Well Sense Health Plan** (**WS**).

1. Executive Summary

The New Hampshire Department of Health and Human Services (DHHS) is responsible for the ongoing monitoring and oversight of its contracted Medicaid managed care organizations (MCOs) that deliver services to members under the Medicaid Care Management (MCM) Program. As part of its responsibility to monitor and oversee these MCOs, DHHS requested its external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG), to validate the adequacy of the provider networks used by the MCOs to provide required physical health, behavioral health, and pharmacy services for Medicaid members in compliance with the State's access requirements. This is the first year in which HSAG has conducted a network adequacy validation (NAV) in New Hampshire.

The purpose of the state fiscal year (SFY) 2023 NAV was to determine if the MCOs complied with the State's geographic access standards outlined in their contracts and the DHHS MCM Quality Strategy for SFY 2023.

The New Hampshire MCOs included in the contract year for SFY 2023 are listed below:

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

HSAG conducted the following activities to assess the adequacy of the MCOs' compliance with the MCM Service Contract standards for geographic access to care:

- **Network Capacity Analysis:** New Hampshire requires MCOs to meet network capacity standards for five types of provider: Masters Level Alcohol and Drug Counselors (MLADCs), opioid treatment providers (OTPs), buprenorphine prescribers, residential substance use disorder (SUD) treatment programs, and peer recovery programs. For each of these five categories of SUD providers or services, MCOs are required to contract with a minimum percentage of the total providers licensed and practicing in the State, and no less than two per public health region unless there are less than two providers in the region.[1-1] HSAG assessed whether each MCO met these standards by comparing the number of providers contracted with the MCOs' provider network to the total number of licensed and practicing providers in the State and in each public health region.
- **Geographic Network Distribution Analysis:** New Hampshire also requires MCOs to meet geographic access standards by providing access to a minimum number of network providers within specific time-distance parameters from members' residences. These standards apply to a broad range of providers, including primary care providers (PCPs), mental health providers, hospitals, and several types of physician specialists. The broader range of SUD providers, including SUD providers or services not covered by the specific network capacity standards discussed in the network capacity

[1-1] New Hampshire DHHS Medicaid Care Management Services Contract, Amendment #8, Section 4.7.3.4

analysis, and are also included in this analysis. Table 2-2 contains a complete list of the provider categories and the corresponding time-distance standards. For each MCO and county, HSAG calculated the percentage of members able to access care within the time and distance requirements defined in the DHHS MCM Services Contract. HSAG also calculated the average distance members had to travel to the first, second, and third closest providers for each provider category.

- **Comparative Assessment of Standards:** At New Hampshire's request, HSAG conducted a systematic review of geographic access standards in other states to help DHHS evaluate its defined NAV geographic access standards.

Key Findings

Network Capacity Analysis

New Hampshire's SUD provider network capacity adequacy standards, shown in Table 2-1, require each MCO to contract with a given percentage of the State's licensed and practicing providers (State standard), and for four of the categories, a minimum of two providers in each of 13 public health regions (regional standard).[1-2] The standard for Peer Recovery Programs requires each MCO to contract with all willing programs in New Hampshire, and has no regional standard. DHHS and HSAG collaborated to obtain the best available data to identify the complete statewide provider lists in order to assess the MCOs' compliance with State and regional standards. For a full discussion, see Appendix A. Methodology.

The results show few discernable patterns. All MCOs met regional standards for buprenorphine prescribers but did not meet the statewide standard. However, this result must be interpreted with caution due to potential issues with defining the number of buprenorphine prescribers, as discussed later in this report. Conversely, all MCOs met the statewide standard for residential SUD treatment programs, while all three failed the regional requirement. Two MCOs (**ACNH** and **NHHF**) met both the State and regional requirements for one provider type, opioid treatment providers (OTPs), while **WS** failed both standards. Results are shown in Table 3-1 through Table 3-5.

Buprenorphine prescribers, OTPs, and master licensed alcohol and drug counselors (MLADCs) demonstrated the best results across the MCOs. This may be a stronger indicator of data quality and availability than of true member access, since these provider categories can be mapped to specific professional credentials that MCOs have historically tracked and/or are subject to federal regulation. The results suggest that most residential SUD treatment programs are available at the State level but are much less available across the public health regions.

[1-2] If an MCO contracted with a provider that was the only one available in a public health region, the MCO met the requirement. If an MCO could not contract with a provider in a public health region because none were available, the MCO met the requirement.

Geographic Network Distribution Analysis

DHHS has set high expectations for its contracted MCOs, requiring them to provide access to 100 percent of members within DHHS' time and distance standards. MCOs varied in their ability to meet the 100 percent standard, as shown in Table 3-6. For those provider categories with specific time-distance standards, **NHHF** met the standards for 68.4 percent of provider categories (13 of 19), while **ACNH** and **WS** each met the standards for 63.2 percent of provider categories (12 of 19). However, none of the results fell below 98.8 percent, indicating very strong performance for the three MCOs across the access standards.

Primary Care Providers (PCPs): All three MCOs provided access for 100 percent of their members to at least two PCPs within the geographic access standards for PCPs, among several other provider categories, as shown in Table 3-6.

Specialists: Although all MCOs met the standard of providing access to at least one specialist for 100 percent of their members, when applying the standard individually to key types of specialists (as requested by DHHS), the results varied more, as shown in Table 3-7. Again, many results met the 100 percent standard—**ACNH** for 15 of 26 provider categories (57.7 percent), and **NHHF** and **WS** each for 11 of 26 provider categories (42.3 percent).

MCOs provided access to less than 98.8 percent of members in the following categories:

- For **ACNH**, 95.3 percent of members had access to an adult allergist; 77.0 percent of pediatric members had access to a pediatric allergist, and 97.7 percent of members had access to an adult ophthalmologist. HSAG did not identify pediatric ophthalmologists in the MCO's submitted data. Additionally, HSAG did not identify any SUD providers specializing in pediatric populations in the MCO's submitted data leaving general adult providers to serve the pediatric populations.
- For **NHHF**, 97.1 percent of members had access to a pediatric ophthalmologist, and 92.7 percent of members had access to an adult allergist. Additionally, HSAG did not identify any SUD providers specializing in pediatric populations in the MCO's submitted data leaving general adult providers to serve the pediatric populations.
- For **WS**, 95.1 percent of members had access to an adult allergist, and 92.1 percent of members had access to a pediatric otolaryngologist. HSAG did not identify any pediatric ophthalmologists in the MCO's submitted data. Additionally, HSAG did not identify any SUD providers specializing in pediatric populations in the MCO's submitted data leaving general adult providers to serve the pediatric populations.

Hospitals: All three MCOs met the standard for providing access to at least one hospital within 45 minutes travel time for 100 percent of their members. The results for tertiary or specialized services (i.e., level I or level II trauma centers and level III or level IV neonatal intensive care units [NICUs]) were slightly lower but still serving between 99.5 percent and 99.9 percent of members within the standard.

Recommendations

DHHS Recommendations

- Due to the challenges surrounding quantifying the statewide denominators for SUD providers and assigning providers to public health regions, HSAG recommends that the network capacity analysis be considered for information only at this point, not as an indication that MCOs met (or failed to meet) particular standards.
- For SUD categories that DHHS is scrutinizing carefully in a capacity analysis, DHHS should work with the MCOs and other agencies to create and maintain a list of licensed, practicing, and "willing" (where applicable) providers. In addition to using this list for analyses, MCOs could also use it to remain aware of the full range of potential contracting partners, which is especially critical where DHHS expects contracting with 100 percent of providers (i.e., willing peer recovery programs). To be most helpful, such lists should contain necessary identifying information including provider national provider identifiers (NPIs) or other distinguishing identification numbers, designations for individual and group providers, and addresses for all locations where services are provided. This information will allow the MCOs to ensure they are meeting both the required statewide and regional standards.
- DHHS should work with HSAG and the MCOs to improve the quality of reported data. This could include requiring MCOs to collect and maintain New Hampshire Medicaid provider type and specialty codes as defined in the Provider Billing Manual or collaborating with the MCOs to create and use a standardized approach (i.e., provider crosswalk) to classify provider categories for NAV activities. DHHS could encourage MCOs to carefully distinguish between individual and organizational/facility records for provider types that include both individual and organizational/facility providers. As an example, a record for an individual physician working in a group practice should have an individual provider type, an individual provider specialty, and an individual-level taxonomy.
- DHHS may consider conducting an in-depth review of provider categories for which each MCO did not meet the geographic access standards, with the goal of determining whether or not the failure of the MCO to meet the standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area. Based on the findings of this review, DHHS may consider adjusting the geographic access standards or setting different standards based on urbanicity. Future analyses should evaluate the extent to which the MCOs have requested exemptions from DHHS for provider categories for which providers may not be available or willing to contract with the MCOs.
- 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 the care they have received.
- DHHS may consider collaborating with HSAG to design and implement a focus study to investigate selected topics regarding access to care among Medicaid members by geographic region. Depending on available resources, study topics may include evaluating health disparities affecting access to care or the potential for in-network providers who are not providing services to Medicaid members (i.e., phantom provider network assessment).

MCO Recommendations

MCO-specific appendices C through F reflect MCO-specific recommendations. In general, based on the results and conclusions presented in this report, HSAG recommends that the MCOs consider the following to strengthen provider networks and ensure members' timely access to healthcare providers:

- For the provider categories for which each MCO did not meet the time-distance standard, the MCO should assess whether this is due to a lack of providers available for contracting in the area, a lack of providers willing to contract with the MCO, the inability to identify the providers in the data, or other reasons.
- MCOs should continue to monitor processes for creating the provider network data files and review the file for accuracy prior to submitting it to HSAG.

2. Overview

Introduction

Validation of network adequacy is a mandatory EQR activity pursuant to Title 42 Code of Federal Regulations (CFR) §438.358(b)(1)(iv).[2-1]

Methodology

DHHS and the MCOs provided Medicaid member and provider data effective as of December 1, 2022. DHHS also provided auxiliary information to identify the MLADCs, OTPs, buprenorphine prescribers, residential SUD treatment programs, and willing peer recovery programs licensed and doing business in the State of New Hampshire. The HSAG team supplemented this information with additional information from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Network Capacity Analysis

HSAG conducted the network capacity analysis by comparing the number of providers associated with each MCO's provider network relative to the total licensed and practicing providers in the State and in each public health region for the five specific provider categories established by DHHS listed in Table 2-1.

Table 2-1—SFY 2023 Provider Capacity Standards

Provider Category/Service	Requirement
MLADCs[1]	The MCO Participating Provider Network shall include seventy percent (70%) of all such providers licensed and practicing in New Hampshire and no less than two (2) providers in any public health region unless there are less than two (2) such providers in the region.
OTPs[2]	The MCO Participating Provider Network shall include seventy-five percent (75%) of all such providers licensed and practicing in New Hampshire and no less than two (2) providers in any public health region unless there are less than two (2) such providers in the region.

[2-1] CMS issued its new External Quality Review (EQR) Protocols in February 2023. The activities described in the protocol must be implemented beginning in February 2024 and validated in EQRO technical reports due in April 2025. This report does not apply the new protocols.

Provider Category/Service	Requirement
Buprenorphine Prescribers[3]	The MCO Participating Provider Network shall include seventy-five percent (75%) of all such providers licensed and practicing in New Hampshire and no less than two (2) providers in any public health region unless there are less than two (2) such providers in the region.
Residential SUD Treatment Programs[4]	The MCO Participating Provider Network shall include fifty percent (50%) of all such providers licensed and practicing in New Hampshire and no less than two (2) providers in any public health region unless there are less than two (2) such providers in the region.
Peer Recovery Programs[5]	The MCO's Participating Provider Network shall include one hundred percent (100%) of all such willing programs in New Hampshire.

[1] DHHS provided a list of licensed and practicing MLADCs in the State using State licensure files. HSAG also identified MLADCs in the provider data submitted by MCOs using New Hampshire Medicaid Provider Type Codes 220 and 221 and provider specialty and taxonomy information.

[2] DHHS provided a list of licensed and practicing OTPs. HSAG supplemented that list with OTPs identified in the MCOs' provider data and providers identified by SAMHSA.

[3] HSAG obtained a list of buprenorphine prescribers from SAMHSA, through a link provided by DHHS on 11/07/2022. While accurate at that time, DHHS acknowledges there have been subsequent changes to federal reporting requirements that are not reflected in the list.

[4] DHHS provided a list of licensed and practicing residential SUD treatment programs. HSAG identified additional programs in MCO data using New Hampshire Medicaid Provider Type Code 223 and providers identified by SAMHSA.

[5] DHHS provided the State-Funded Recovery Community Organizations in New Hampshire guide from the New Hampshire Bureau of Drug & Alcohol Services dated August 2022. HSAG identified additional programs in MCO data using New Hampshire Medicaid Provider Type Code 228 and provider type, specialty, and taxonomy information.

Geographic Network Distribution Analysis (Time and Distance Analysis)

HSAG conducted a geographic distribution analysis of the MCO-contracted providers relative to the MCOs' members. This analysis evaluated whether each MCO's Medicaid members had access to network providers within the time and distance standards set by DHHS and listed in Table 2-2.

Table 2-2—SFY 2023 Provider Categories and Time-Distance Standards

Provider/Service	Requirement
Adult and Pediatric PCPs[1]	Two (2) within forty (40) driving minutes or fifteen (15) driving miles
Adult Specialists[2]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Pediatric Specialists[2]	One (1) within one hundred twenty (120) driving minutes or eighty (80) driving miles
OB/GYN Providers[3]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospitals	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Adult and Pediatric Mental Health Providers[4]	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles

Provider/Service	Requirement
Pharmacies	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles
Tertiary or Specialized Services (trauma, neonatal)[5]	One (1) within one hundred twenty (120) driving minutes or eighty (80) driving miles
Individual/Group MLADCs[6]	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles
SUD Programs[7]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Adult Medical Day Care[8]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospice[9]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Office-based Physical Therapy(PT)/Occupational Therapy(OT)/Speech Therapy(ST)[10]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

[1] PCPs included, but were not limited to, pediatricians, family practitioners, general practitioners, internists, physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNPs), as designated by the MCO.

[2] DHHS selected the types of adult and pediatric specialists to be assessed, which included allergists, cardiologists, dermatologists, endocrinologists, otolaryngologists (Ear, Nose, Throat [ENTs]), gastroenterologists, hematologists and oncologists, neurologists, ophthalmologists, orthopedists, pulmonologists, SUD providers, and urologists.

[3] Obstetrics and gynecology (OB/GYN) providers included physicians, nurse practitioners (NPs), and/or women's health specialists offering prenatal care services (e.g., nurse midwives).

[4] Mental health providers included physicians, psychologists, psychiatrists, psychiatric NPs, and licensed counselors excluding those who specialize in providing SUD services, and including but not limited to New Hampshire Medicaid Provider Type Codes 002, 009, 042, 093, 208, 220, 221, 225, 226, 229, and 230.

[5] Hospitals that provide tertiary or specialized services were defined as those designated level I or level II trauma centers according to American College of Surgeons (ACS) criteria, and those with a designated level III or level IV NICU according to the Centers for Disease Control and Prevention (CDC).

[6] MLADCs included master level alcohol and drug counselors licensed by the New Hampshire Board of Medicine, and those identified by New Hampshire Medicaid Provider Type Codes 220 and 221 or otherwise identified in MCO data by provider specialty and taxonomy.

[7] SUD programs included SUD outpatient programs identified by DHHS, and providers identified in MCO data by provider type, specialty codes, and taxonomy codes, including but not limited to New Hampshire Medicaid Provider Type Codes 222 and 223. HSAG identified additional SUD programs identified by SAMHSA.

[8] Adult medical day care providers included but were not limited to those identified with New Hampshire Medicaid Provider Type Code 058 and those identified in MCO data by specialty or taxonomy.

[9] Hospice providers included agencies identified with New Hampshire Medicaid Provider Type Code 006 and those identified in MCO data by specialty or taxonomy.

[10] Office-based PT/OT/ST providers included but were not limited to those identified with New Hampshire Medicaid Provider Type Codes 039, 040, 041, 206, 207, and 209, and those identified in MCO data by specialty or taxonomy.

To provide a comprehensive view of geographic access, HSAG calculated the following spatial-derived metrics for the provider categories identified in Table 2-2.

- **Percentage of members with access to providers within time and distance standards**:[2-2] A higher percentage of members with access according to standards indicates better geographic distribution of an MCO's providers in relation to its Medicaid members. This metric was calculated for those provider categories for which DHHS has identified a geographic access standard, and ascertained the extent to which each MCO met those standards.
- **Average travel distance (driving distance in miles) or travel time[2-3] (in minutes) to the nearest one, two, and three providers**: A shorter distance or shorter travel time indicates greater accessibility to providers since individuals must travel fewer miles or minutes to access care. In addition to the basic time and distance results, a second metric was calculated indicating the average travel time and/or distance members had to travel to their nearest first three providers.

HSAG used Quest Analytics software (version 2022.4) to calculate the duration of travel time or physical travel distance between the address of specific members and their first, second, and third nearest providers for all provider categories identified in Table 2-2. HSAG stratified all results by MCO.

Appendix A contains a more complete description of the methodology.

Comparative Assessment of State Standards

HSAG conducted a systematic review of geographic access standards in select states to assist DHHS in reviewing the adequacy of its network access standards. HSAG examined states located in the New England and Mid-Atlantic U.S. Census Bureau divisions to identify states most similar to New Hampshire in terms of population size and density, geography, and approach to Medicaid managed care.

Several New England Division state populations were around the same or less than New Hampshire's 1.4 million in 2021. HSAG selected Rhode Island, with 1.1 million residents, and Vermont, with 0.65 million residents (as of 2021).[2-4] These states are both broadly similar in geography with a mixture of urban and rural areas. Vermont, like New Hampshire, includes large areas of mountainous, sparsely populated terrain. HSAG also looked at Middle Atlantic Division states, which generally had much larger populations than New Hampshire. New Jersey was selected for comparison, however, because it

[2-2] The percentage of members within predefined standards was only calculated for provider categories with predefined access standards.

[2-3] Average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid members; the shorter the average drive time, the more similar the distribution of providers is relative to members. Quest Analytics estimated drive times based on the following drive speeds: urban areas are estimated at a drive speed of 30 miles per hour, suburban areas are estimated at a drive speed of 45 miles per hour, and rural areas are estimated at a drive speed of 55 miles per hour.

[2-4] USAFacts. Our Changing Population. Available at: https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/rhode-island/?endDate=2021-01-01&startDate=2010-01-01 Accessed on: Apr 28, 2023.

provided a good example of access standards tailored to a variety of geographies and levels of urbanicity.

HSAG obtained publicly available documents and examined the selected states' most recent Medicaid managed care contracts, EQRO technical reports, and/or quality strategies for their network adequacy standards, which HSAG then systematically compared.[2-5,2-6,2-7]

[2-5] Rhode Island Medicaid Managed Care Program UnitedHealthcare Community Plan of Rhode Island, 2020 External Quality Review Annual Technical Report, published April 2022. Available at: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-04/RI%202020%20EQR%20Annual%20Techical%20Report%20for%20Neighborhood%20Health%20Plan%20-%20Final.pdf. Accessed on: Apr 24, 2023.

[2-6] Access to Care Plan Department of Vermont Health Access, March 18, 2022. Available at: https://dvha.vermont.gov/sites/dvha/files/doc_library/Access%20to%20Care%20Plan%202022.pdf. Accessed on: Apr 24, 2023.

[2-7] New Jersey Department of Human Services Division of Medical Assistance and Health Services. Division of Medical Assistance and Health Services Quality Strategy, updated June 2014. Available at: https://www.nj.gov/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf. Accessed on: Apr 24, 2023.

3. Findings

This section presents the findings and results from the network capacity analysis, geographic network distribution analysis, and the comparative assessment of state standards.

Network Capacity Analysis

HSAG presents network capacity results below by provider category.

MLADCs

Table 3-1 displays the statewide network capacity analysis results for MLADCs (i.e., the percentage of providers licensed and practicing within New Hampshire and the percentage of public health regions in which each MCO contracted with the required number of providers). Red shading indicates that the MCO did not meet part of the standard. A checkmark in the Requirement Met column indicates that the MCO met both standards; an "X" indicates that the MCO failed to meet both standards for that provider category. Appendices C, D, and E list the public health regions in which each MCO did not meet the required minimum number of providers.

Table 3-1—Statewide Network Capacity Analysis Results for MLADCs by MCO

MCO	Standard	Percent of Providers in the State	Percent of Regions With Required Number of Providers per Region	Requirement Met
ACNH	70% of all providers / 2 providers per region*	34.2%	100.0%	X
NHHF	70% of all providers / 2 providers per region*	16.5%	92.3%	X
WS	70% of all providers / 2 providers per region*	11.9%	76.9%	X

Note: Red cells indicate that the MCO did not meet applicable capacity requirements for this provider category.
*At least two providers were identified in each region.

These results indicate that none of the MCOs were able to meet the statewide standard of contracting with 70 percent of the licensed and practicing MLADCs. Only one of the three MCOs was able to contract with the minimum number of providers in each public health region. None of the MCOs met both parts of the standard.

OTPs

Table 3-2 displays the statewide network capacity analysis results for OTPs (i.e., the percentage of providers licensed and practicing within New Hampshire and the percentage of public health regions in which each MCO contracted with the required number of providers). Red shading indicates that the MCO did not meet part of the standard. A checkmark in the Requirement Met column indicates that the MCO met both standards; an "X" in the Requirement Met column indicates that the MCO failed to meet both standards for that provider category. Appendices C, D, and E list the public health regions in which each MCO did not meet the required minimum number of providers.

Table 3-2—Statewide Network Capacity Analysis Results for OTPs by MCO

MCO	Standard	Percent of Providers in the State	Percent of Regions With Required Number of Providers per Region	Requirement Met
ACNH	75% of all providers / 2 providers per region*	92.3%	100.0%	✓
NHHF	75% of all providers / 2 providers per region*	92.3%	100.0%	✓
WS	75% of all providers / 2 providers per region*	61.5%	76.9%	X

Note: Red cells indicate that an MCO did not meet applicable capacity requirements for this provider category.
*Two providers are required in any public health region unless there are less than two providers in the region. Only one provider was identified in each the following regions: Capital, Greater Monadnock, Greater Nashua, South Central, Strafford County, Upper Valley, and Winnipesaukee. No providers were identified in each of the following regions: Carroll County, Central New Hampshire, Greater Sullivan, and North Country.

These results indicate that contracting with sufficient OTPs to meet the State's standards presented less challenge than contracting with MLADCs. Two MCOs were able to meet both parts of the standard for OTPs, with access rates substantially greater than the results for the third MCO, which met neither requirement.

Buprenorphine Prescribers

Table 3-3 displays the statewide network capacity analysis results for buprenorphine prescribers (i.e., the percentage of providers licensed and practicing within New Hampshire and the percentage of public health regions in which each MCO contracted with the required number of providers).

Table 3-3—Statewide Network Capacity Analysis Results for Buprenorphine Prescribers by MCO

MCO	Standard*	Percent of Providers in the State	Percent of Regions With Required Number of Providers per Region
ACNH	75% of all providers/ 2 providers per region*	63.5%	100.0%
NHHF	75% of all providers/ 2 providers per region*	64.8%	100.0%
WS	75% of all providers/ 2 providers per region*	50.5%	100.0%

Note: HSAG obtained a list of buprenorphine prescribers from SAMHSA, through a link provided by DHHS on 11/07/2022. While accurate at that time, DHHS acknowledges there have been subsequent changes to federal reporting requirements that are not reflected in the list. Results should be interpreted with caution.
*At least two providers were identified in each region.

These results indicate that all three MCOs were able to meet the regional standard, contracting with available buprenorphine prescribers in all public health regions. However, all three faced significant challenges meeting the statewide standard of contracting with 75 percent of licensed and practicing buprenorphine prescribers.

Residential SUD Treatment Programs

Table 3-4 displays the statewide network capacity analysis results for residential SUD treatment programs (i.e., the percentage of providers licensed and practicing within New Hampshire and the percentage of public health regions in which each MCO contracted with the required number of providers). Red shading indicates that the MCO did not meet part of the standard. A checkmark in the Requirement Met column indicates that the MCO met both standards; an "X" indicates that the MCO failed to meet both standards for that provider category. Appendices C, D and E list the public health regions in which each MCO did not meet the required minimum number of providers.

Table 3-4—Statewide Network Capacity Analysis Results for Residential SUD Treatment Programs by MCO

MCO	Standard	Percent of Providers in the State	Percent of Regions With Required Number of Providers per Region	Requirement Met
ACNH	50% of all providers/ 2 providers per region*	64.0%	38.5%	X
NHHF	50% of all providers/ 2 providers per region*	60.0%	38.5%	X

MCO	Standard	Percent of Providers in the State	Percent of Regions With Required Number of Providers per Region	Requirement Met
WS	50% of all providers/ 2 providers per region*	56.0%	69.2%	X

Note: Red cells indicate that the MCO did not meet applicable capacity requirements for this provider category.
*Two providers are required in any public health region unless there are less than two providers in the region. Only one provider was identified in each the following regions: Carroll County, Central New Hampshire, Greater Sullivan, and Seacoast.

These results indicate that all three MCOs were able to meet the statewide standard of contracting with 50 percent of all residential SUD treatment program providers, but none met the regional access requirement.

Peer Recovery Programs

Table 3-5 displays the statewide network capacity analysis results for peer recovery programs (i.e., the percentage of willing programs in New Hampshire identified in each MCO's provider data).

Table 3-5—Statewide Network Capacity Analysis Results for Willing Peer Recovery Programs by MCO

MCO	Percent of Providers in the State
ACNH	64.3%
NHHF	60.7%
WS	3.6%

Note: WS indicated that peer recovery support services were provided and billed from a variety of SUD and mental health providers but were not separately identified through their provider data.

These results indicate that all MCOs faced challenges meeting the statewide standard of access to 100 percent of willing peer recovery programs in the State, although ACNH and NHHF provider data identified 64.3 percent and 60.7 percent of the State willing peer recovery programs, respectively. WS data permitted identification of only 3.6 percent of the State's peer recovery programs, however WS explained that peer recovery services were not tracked in their provider data. Unlike the other four network capacity standards, there is no regional requirement for this provider category.

Geographic Network Distribution Analysis

HSAG presents the results of the time-distance analysis separately for the provider categories with specific access standards set by DHHS, and the physician specialists that DHHS selects annually.

Adherence to Time-Distance Standards

HSAG examined results for all provider categories that are specifically covered by the access standards, shown in Table 3-6, and also presented a separate table of results for physician specialists requested by DHHS, Table 3-7.

Table 3-6 displays the percentage of each MCO's members who have the access to care required by contract standards for all applicable provider categories by MCO as defined in Table 2-2. Red shading indicates that the MCO did not meet minimum geographic access standards for a specific provider category. Appendices C, D, and E list the counties where the standards were not met, by MCO.

Table 3-6— Percentage of Members With Required Access to Care by Provider Category and MCO

	ACNH	NHHF	WS
Provider Category	Percent of Members With Required Access	Percent of Members With Required Access	Percent of Members With Required Access
PCP, Adult	100.0%	100.0%	100.0%
PCP, Pediatric	100.0%	100.0%	100.0%
Specialist, Adult	100.0%	100.0%	100.0%
Specialist, Pediatric[1]	100.0%	100.0%	100.0%
OB/GYN Providers	100.0%	100.0%	100.0%
Hospitals	100.0%	100.0%	100.0%
Tertiary or Specialized Services: Level I or Level II Trauma Centers	> 99.9%	100.0%	99.6%
Tertiary or Specialized Services: Level III or Level IV NICU	> 99.9%	99.5%	99.5%
Pharmacies	100.0%	100.0%	100.0%
Mental Health Providers, Adult	100.0%	100.0%	99.9%
Mental Health Providers, Pediatric	> 99.9%	99.4%	98.8%
Individual/Group MLADCs[2]	100.0%	99.3%	99.9%
Substance Use Disorder Programs	100.0%	100.0%	100.0%
Adult Medical Day Care	99.4%	98.8%	99.3%
Hospice	99.9%	99.8%	99.9%
Office-Based OT/PT /ST[3]	100.0%	100.0%	100.0%
OT	> 99.9%	100.0%	100.0%
PT	100.0%	100.0%	100.0%

Provider Category	ACNH Percent of Members With Required Access	NHHF Percent of Members With Required Access	WS Percent of Members With Required Access
ST	99.9%	99.8%	100.0%

Note: Red cells indicate that the MCO did not meet the minimum geographic access standards for a specific provider category.
[1] The standard refers to specialists as a group, which includes allergists, cardiologists, dermatologists, endocrinologists, otolaryngologists (ENTs), gastroenterologists, hematologists and oncologists, neurologists, ophthalmologists, orthopedists, pulmonologists, SUD providers, and urologists. These are combined here and considered separately in Table 3-7.
[2] No group MLADCs were identified in plan data, so all MLADCs are individual providers.
[3] The standard refers to these therapists as a group. However, the three therapist types are also presented separately.

These results indicate that all three MCOs were broadly successful at meeting the time-distance standards set by DHHS. **NHHF** met the 100 percent standard for 13 of the 19 provider categories listed above, while **ACNH** and **WS** met the standard for 12 of the 19 provider categories.

Across all three MCOs, the 100 percent standard was met for the following provider categories:

- PCP, Adult and Pediatric
- Specialist, Adult and Pediatric
- OB/GYN Providers
- Hospitals
- Pharmacies
- SUD Programs
- Office-Based OT/ PT/ST
- PT

For provider categories where MCOs were unable to meet the 100 percent score set by DHHS, very few missed the mark by more than a few tenths of a percent, and no final result was less than 98.8 percent. However, none of the three MCOs met the 100 percent standard in the following provider categories:

- Tertiary or Specialized Services: Level III or Level IV NICU
- Mental Health Providers, Pediatric
- Adult Medical Day Care
- Hospice

Table 3-7 examines access to specialists by provider category and displays the percentage of each MCO's members who have the access to care required by contract standards for applicable adult and pediatric specialist providers. DHHS selected these specialties, and they are not named separately in the access standards. Red shading indicates that the MCO did not meet the minimum geographic access

standards for a specific provider category. Appendices C, D, and E list the counties where the standards were not met, by MCO.

Table 3-7—Percentage of Members With Required Access to Care by Adult and Pediatric Specialties and MCO

	ACNH	NHHF	WS
Provider Category	Percent of Members With Required Access	Percent of Members With Required Access	Percent of Members With Required Access
Allergist, Adult	95.3%	92.7%	95.1%
Allergist, Pediatric	77.0%	99.9%	99.6%
Cardiologist, Adult	100.0%	99.1%	99.5%
Cardiologist, Pediatric	100.0%	100.0%	100.0%
Dermatologist, Adult	99.9%	99.7%	99.9%
Dermatologist, Pediatric	> 99.9%	99.9%	99.9%
Endocrinologist, Adult	99.5%	99.2%	99.6%
Endocrinologist, Pediatric	100.0%	99.9%	99.9%
Gastroenterologist, Adult	100.0%	100.0%	100.0%
Gastroenterologist, Pediatric	100.0%	99.9%	99.9%
Hematologists and Oncologists, Adult	100.0%	100.0%	100.0%
Hematologists and Oncologists, Pediatric	> 99.9%	99.9%	99.9%
Neurologist, Adult	100.0%	100.0%	100.0%
Neurologist, Pediatric	> 99.9%	100.0%	99.9%
Ophthalmologist, Adult	97.7%	100.0%	100.0%
Ophthalmologist, Pediatric	0.0%	97.1%	0.0%
Orthopedist, Adult	100.0%	100.0%	100.0%
Orthopedist, Pediatric	> 99.9%	99.9%	99.9%
Otolaryngologist, Adult	100.0%	100.0%	100.0%
Otolaryngologist, Pediatric	> 99.9%	99.9%	92.1%
Pulmonologist, Adult	100.0%	100.0%	100.0%
Pulmonologist, Pediatric	100.0%	99.9%	99.9%
SUD Providers, Adult[1]	100.0%	99.8%	100.0%
SUD Providers, Pediatric[1]	100.0%	100.0%	100.0%

Provider Category	ACNH Percent of Members With Required Access	NHHF Percent of Members With Required Access	WS Percent of Members With Required Access
Urologist, Adult	100.0%	100.0%	100.0%
Urologist, Pediatric	100.0%	99.9%	99.9%

Note: Red cells indicate that the MCO did not meet the minimum geographic access standards for a specific provider category.
[1] There was no distinction in plan data between SUD providers who serve pediatric or adult members, so the entire population of SUD providers was used to calculate access to pediatric and adult populations.

Members of all three MCOs often had access to specialty care within the time-distance standards. All **ACNH** members had access within the standard for 15 of the 26 provider specialist categories listed above, while members of **NHHF** and **WS** each had access within the standard for 11 of the 26 provider specialist categories. For provider categories where the MCOs were unable to achieve the 100 percent score set by DHHS, very few missed the mark by more than a few percentage points.

None of the three MCOs were able to provide 100 percent of members access to adult allergists. However, their results were similar, ranging from 92.7 percent to 95.3 percent of members with access in accordance with standards. This suggests a real lack of appropriate available providers, rather than an MCO-specific issue.

On the other hand, several results suggest particular challenges for specific MCOs. Results were widely divergent for levels of access to pediatric ophthalmologists, with two MCOs (**ACNH** and **WS**) appearing to provide no access to these specialists, while **NHHF** provided access to 97.1 percent of its members. **ACNH** had substantially lower levels of access to pediatric allergists than the other MCOs, with only 77.0 percent of members having access (as opposed to **NHHF** with greater than 99.9 percent, and **WS** with 99.6 percent).

Other results that might suggest challenges for particular MCOs are on a smaller scale and less concerning. **WS** provided access to pediatric otolaryngologists for 92.1 percent of members, while both of the other MCOs achieved access for at least 99.9 percent of members. **ACNH** provided access to adult ophthalmologists for 97.7 percent of members, while the other MCOs achieved 100 percent access for that provider category.

Travel Times to Nearest Providers

HSAG examined results for all provider categories that are specifically covered by the access standards, shown in Table 3-8, and also presented a separate table of results for physician specialists requested by DHHS, Table 3-9.

Table 3-8 examines results for provider categories with access to care required by contract standards, displaying the statewide average travel times (in minutes) to the first, second, and third nearest providers for members receiving services through each MCO.

Table 3-8— Statewide Average Travel Times (Minutes) by MCO*

	ACNH			NHHF			WS		
	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest
Provider Category	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)
PCP, Adult	2.8	3.0	3.1	2.5	2.6	2.8	2.4	2.6	2.8
PCP, Pediatric	3.0	3.1	3.3	2.7	2.8	3.1	2.7	3.0	3.1
Specialist, Adult	3.0	3.9	4.3	3.3	4.0	4.5	3.6	4.3	4.7
Specialist, Pediatric[1]	4.0	5.2	5.9	5.3	7.1	8.0	7.2	9.2	10.9
OB/GYN Providers	4.9	5.4	5.7	4.7	5.7	6.6	4.4	5.2	5.9
Hospitals	6.4	12.7	18.5	13.8	24.2	32.7	9.5	20.1	26.2
Tertiary or Specialized Services: Level I or Level II Trauma Centers	25.2	36.1	46.3	21.1	31.3	41.4	29.2	47.1	62.1
Tertiary or Specialized Services: Level III or Level IV NICU	23.9	39.3	48.1	32.0	48.3	64.0	40.2	58.2	93.5
Pharmacies	3.0	4.2	5.5	3.2	4.6	6.2	3.0	4.4	5.9
Mental Health Providers, Adult	3.2	4.0	4.5	2.5	3.3	3.8	5.5	7.8	9.8
Mental Health Providers, Pediatric	10.0	15.9	20.0	11.2	17.9	23.1	8.2	11.2	14.2
Individual/Group MLADCs[2]	3.9	4.9	5.5	7.4	8.8	12.1	6.5	11.0	13.6
Substance Use Disorder Programs	5.3	7.9	9.6	6.3	9.1	11.7	6.8	10.5	12.7
Adult Medical Day Care	18.2	28.1	36.1	19.4	33.4	43.4	21.8	36.5	40.8
Hospice	10.5	16.7	22.7	9.8	16.9	21.1	12.9	22.3	29.4
Office-Based OT/PT/ST[3]	4.3	5.1	5.8	3.5	4.4	4.7	3.1	3.7	4.2
OT	8.5	11.1	13.2	6.2	7.8	8.9	5.8	7.3	9.2

	ACNH			NHHF			WS		
	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest
Provider Category	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)
PT	5.5	6.2	7.0	4.0	4.8	5.4	3.5	4.4	5.0
ST	10.1	12.0	13.6	8.8	11.9	12.1	7.1	8.4	9.7

*Statewide average travel times may include out-of-state providers.
[1] The standard refers to specialists as a group, which includes allergists, cardiologists, dermatologists, endocrinologists, otolaryngologists (ENTs), gastroenterologists, hematologists and oncologists, neurologists, ophthalmologists, orthopedists, pulmonologists, SUD providers, and urologists. These are combined here and considered separately in Table 3-9.
[2] No group MLADCs were identified in plan data, so all MLADCs are individual providers.
[3] The standard refers to these therapists as a group. However, the three therapist types are also presented separately.

For most provider categories across all three MCOs, average travel time were relatively short. For all three MCOs, average travel times to the first, second, and third nearest provider were less than 10 minutes for adult and pediatric PCPs, adult specialists, OB/GYN providers, pharmacies, adult mental health providers, office-based OT/PT/ST, and PT provider types. However, across all three MCOs, average travel times for tertiary specialized services level I or level II trauma centers and level III or level IV NICUs were all greater than 20 minutes to the first nearest provider.

Table 3-9 examines results by provider specialty and population, and displays the statewide average travel times (in minutes) to the first, second, and third nearest providers for members receiving services through each MCO.

Table 3-9—Statewide Average Travel Times (Minutes) for Adult and Pediatric Specialties by MCO*

	ACNH			NHHF			WS		
	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest
Provider Category	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)
Allergist, Adult	16.0	17.3	23.4	18.4	19.3	23.9	18.5	22.7	26.0
Allergist, Pediatric	103.5	103.5	103.5	28.3	32.9	42.8	32.9	47.8	48.1
Cardiologist, Adult	7.0	8.1	9.0	14.1	14.9	17.8	12.2	19.6	28.3
Cardiologist, Pediatric	17.8	21.4	22.1	15.8	17.9	21.9	20.7	22.4	24.9
Dermatologist, Adult	12.0	14.4	15.8	11.8	13.4	17.4	12.2	13.2	14.4

	ACNH			NHHF			WS		
	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest
Provider Category	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)
Dermatologist, Pediatric	35.5	67.2	68.0	20.8	31.8	36.0	36.5	67.8	68.7
Endocrinologist, Adult	11.5	15.5	18.6	12.4	16.1	17.4	11.9	13.0	18.9
Endocrinologist, Pediatric	26.2	29.0	29.9	18.6	22.8	23.4	19.5	23.8	26.0
Gastroenterologist, Adult	8.7	10.0	10.7	8.3	8.6	9.0	8.8	9.0	9.9
Gastroenterologist, Pediatric	22.6	23.8	28.4	21.2	21.7	22.6	22.4	24.8	31.8
Hematologists and Oncologists, Adult	8.9	10.8	12.7	6.4	8.0	9.4	7.3	9.4	12.0
Hematologists and Oncologists, Pediatric	34.9	64.0	64.0	29.1	33.4	34.2	34.3	36.4	64.3
Neurologist, Adult	6.6	8.1	8.9	6.5	7.4	8.8	6.4	7.9	9.0
Neurologist, Pediatric	21.7	23.6	25.6	16.4	19.0	20.8	20.4	24.3	25.0
Ophthalmologist, Adult	17.6	20.6	22.8	7.2	8.9	10.2	7.5	10.0	12.0
Ophthalmologist, Pediatric	—	—	—	38.0	48.4	56.4	—	—	—
Orthopedist, Adult	6.0	6.5	7.1	5.8	6.1	7.2	5.5	6.5	7.9
Orthopedist, Pediatric	35.0	55.6	68.0	57.1	78.0	78.0	46.3	58.1	81.6
Otolaryngologist, Adult	8.9	10.2	16.0	8.3	11.7	13.6	7.5	8.5	11.2
Otolaryngologist, Pediatric	35.4	74.5	89.5	71.1	91.4	97.5	73.2	82.9	98.8
Pulmonologist, Adult	7.3	9.8	11.0	10.9	13.0	15.7	10.7	13.1	14.2

	ACNH			NHHF			WS		
	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest
Provider Category	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)	Time (Min)
Pulmonologist, Pediatric	27.7	30.9	36.9	20.2	26.4	30.5	24.2	26.8	37.4
SUD Providers, Adult[1]	3.8	5.1	5.8	6.4	8.1	10.1	8.3	13.6	19.0
SUD Providers, Pediatric[1]	4.1	5.4	6.1	6.4	8.2	10.2	8.8	14.0	19.6
Urologist, Adult	8.0	8.8	9.8	7.6	8.8	9.2	7.3	8.5	9.4
Urologist, Pediatric	34.7	34.7	63.9	35.2	82.2	110.2	30.9	36.1	47.9

* Statewide average travel times may include out-of-state providers.
— A dash indicates that the MCO had no contracted providers in this category.
[1] There was no distinction in plan data between SUD providers who serve pediatric or adult members, so the entire population of SUD providers was used to calculate access to pediatric and adult populations separately.

For most adult specialist provider categories, the average travel times were relatively short. On average, members of all MCOs were 15 minutes from at least two adult specialists in any given provider category. However, for most of the specialist pediatric provider categories across all three MCOs, members' average travel times were about three times that of adult specialists.

Travel Distances to Nearest Providers

HSAG examined results for all provider categories that are specifically covered by the access standards, shown in Table 3-10, and also presented a separate table of results for physician specialists requested by DHHS, Table 3-11.

Table 3-10 examines results for provider categories with access to care required by contract standards, displaying the statewide average travel distance (in miles) to the first, second, and third nearest providers for members receiving services through each MCO.

Table 3-10—Statewide Average Travel Distances (Miles) by Provider Category and MCO*

	ACNH			NHHF			WS		
	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest
Provider Category	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)
PCP, Adult	2.5	2.6	2.7	2.2	2.4	2.5	2.1	2.3	2.5
PCP, Pediatric	2.7	2.7	2.9	2.4	2.5	2.7	2.4	2.6	2.7
Specialist, Adult	2.7	3.4	3.8	2.9	3.6	4.0	3.2	3.8	4.2
Specialist, Pediatric[1]	3.5	4.6	5.2	4.7	6.3	7.1	6.4	8.2	9.7
OB/GYN Providers	4.3	4.8	5.1	4.1	5.1	5.8	3.9	4.6	5.2
Hospitals	5.5	10.8	15.6	11.7	20.5	26.1	8.2	17.2	21.8
Tertiary or Specialized Services: Level I or Level II Trauma Centers	20.6	28.5	36.8	17.1	26.4	32.6	24.2	36.9	51.9
Tertiary or Specialized Services: Level III or Level IV NICU	19.4	29.8	35.2	25.2	37.2	52.5	29.2	40.8	63.8
Pharmacies	2.7	3.7	4.9	2.8	4.1	5.5	2.6	3.9	5.2
Mental Health Providers, Adult	2.9	3.5	3.9	2.2	2.9	3.4	4.8	6.8	8.5
Mental Health Providers, Pediatric	8.9	14.2	17.7	9.5	15.2	19.4	7.3	10.0	12.7
Individual/Group MLADCs[2]	3.4	4.3	4.8	6.4	7.6	10.5	5.6	9.5	11.7
Substance Use Disorder Programs	4.6	6.9	8.4	5.5	7.9	10.1	5.9	9.0	11.0
Adult Medical Day Care	16.2	24.5	31.3	17.1	29.1	34.9	19.6	32.4	35.8
Hospice	9.2	14.8	20.2	8.7	15.0	18.7	11.5	19.9	25.9

	ACNH			NHHF			WS		
	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest
Provider Category	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)
Office-Based OT/PT/ST[3]	3.8	4.5	5.1	3.1	3.9	4.2	2.7	3.3	3.7
OT	7.6	10.0	11.8	5.5	6.9	7.9	5.1	6.4	8.1
PT	4.8	5.5	6.2	3.5	4.3	4.8	3.1	3.9	4.5
ST	9.1	10.8	12.2	7.8	10.6	10.9	6.2	7.3	8.4

*Statewide average travel distance may include out-of-state providers.
[1] The standard refers to specialists as a group, which includes allergists, cardiologists, dermatologists, endocrinologists, otolaryngologists (ENTs), gastroenterologists, hematologists and oncologists, neurologists, ophthalmologists, orthopedists, pulmonologists, SUD providers, and urologists. These are combined here and considered separately in Table 3-11.
[2] No group MLADCs were identified in plan data, so all MLADCs are individual providers.
[3] The standard refers to these therapists as a group. However, the three therapist types are also presented separately.

Across all three MCOs, the average travel distances were relatively short for most provider categories. For all three MCOs, the average travel distance to the first, second, and third nearest provider was less than 10 miles for adult and pediatric PCPs, adult and pediatric specialists, OB/GYN providers, pharmacies, adult mental health providers, office-based OT/PT/ST, and PT provider types. The average travel distance to tertiary specialized services level I or level II trauma centers and level III or level IV NICUs was much farther for all three MCOs, with the first nearest provider being more than 20 miles away on average.

Table 3-11 displays the statewide average travel distance (in miles) to the first, second, and third nearest providers for members receiving services through each MCO.

Table 3-11— Statewide Average Travel Distances (Miles) for Adult and Pediatric Specialties by MCO

	ACNH			NHHF			WS		
	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest
Provider Category	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)
Allergist, Adult	14.2	15.3	20.7	16.6	17.3	21.4	16.4	20.0	23.1
Allergist, Pediatric	69.2	69.2	69.2	24.3	28.6	37.4	28.2	40.4	40.8
Cardiologist, Adult	6.0	7.1	7.8	12.2	12.8	15.1	10.4	16.1	22.4

	ACNH			NHHF			WS		
	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest
Provider Category	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)
Cardiologist, Pediatric	15.4	18.1	18.8	13.8	15.7	18.7	16.2	17.6	19.7
Dermatologist, Adult	10.7	12.8	14.0	10.5	11.9	15.3	10.9	11.7	12.7
Dermatologist, Pediatric	26.7	49.4	49.9	18.0	25.4	30.7	27.6	50.4	50.9
Endocrinologist, Adult	10.1	13.7	16.3	11.1	14.3	15.5	10.5	11.5	16.5
Endocrinologist, Pediatric	22.5	23.0	23.2	16.4	20.0	20.3	17.2	20.8	22.0
Gastroenterologist, Adult	7.6	8.7	9.4	7.3	7.6	7.9	7.6	7.9	8.6
Gastroenterologist, Pediatric	19.8	20.8	24.3	18.6	19.1	19.7	19.7	21.6	27.1
Hematologists and Oncologists, Adult	7.8	9.3	11.0	5.7	7.1	8.4	6.4	8.3	10.6
Hematologists and Oncologists, Pediatric	26.3	47.6	47.6	25.0	26.1	26.5	26.3	28.0	48.1
Neurologist, Adult	5.7	7.0	7.7	5.7	6.4	7.7	5.6	6.9	7.9
Neurologist, Pediatric	19.1	19.9	21.4	14.3	16.1	17.6	17.7	20.3	20.9
Ophthalmologist, Adult	15.3	17.2	19.1	6.4	7.9	9.1	6.6	8.9	10.7
Ophthalmologist, Pediatric	—	—	—	33.8	39.5	45.6	—	—	—
Orthopedist, Adult	5.2	5.7	6.2	5.1	5.4	6.3	4.9	5.7	7.0
Orthopedist, Pediatric	30.3	43.9	49.6	48.9	66.2	66.6	38.0	47.0	62.0

	ACNH			NHHF			WS		
	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest	First Nearest	Second Nearest	Third Nearest
Provider Category	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)	Dist (Mi)
Otolaryngologist, Adult	7.5	8.6	12.8	7.1	10.1	11.7	6.4	7.3	9.6
Otolaryngologist, Pediatric	26.4	53.3	62.2	51.7	77.1	80.1	58.5	63.9	68.1
Pulmonologist, Adult	6.3	8.5	9.5	9.6	11.3	13.6	9.4	11.5	12.5
Pulmonologist, Pediatric	22.8	25.5	30.5	17.2	22.3	25.5	20.6	22.7	29.8
SUD Providers, Adult[1]	3.3	4.5	5.0	5.6	7.1	8.8	7.3	11.8	16.1
SUD Providers, Pediatric[1]	3.6	4.8	5.3	5.6	7.2	8.9	7.7	12.3	16.6
Urologist, Adult	7.0	7.7	8.7	6.7	7.8	8.2	6.4	7.5	8.3
Urologist, Pediatric	26.3	26.3	47.5	26.3	66.3	85.9	24.7	27.1	37.2

*Statewide average travel distance may include out-of-state providers.
— A dash indicates that the MCO had no contracted providers in this category.
[1] There was no distinction in plan data between SUD providers who serve pediatric or adult members, so the entire population of SUD providers was used to calculate access to pediatric and adult populations.

For most of the specialist adult provider categories, the average travel times were relatively short. Across all three MCOs, members were on average within 15 miles of at least two adult specialists. However, for most of the specialist pediatric provider categories across all three MCOs, the average travel distance was two times that of the adult provider categories.

Comparative Assessment of State Standards

HSAG selected Rhode Island and Vermont from the New England Division of the U.S. Census Bureau, the same division containing New Hampshire, and New Jersey from the Middle Atlantic Division as most comparable in terms of population size, density, and geography. Although the underlying structure

of these states' Medicaid MCOs often differs from New Hampshire's structure in important respects, all have network adequacy standards similar to those used in New Hampshire.[3-1]

Provider Types

Most states assessed in this comparative analysis had specific time and distance standards for the provider types required by Title 42 Code of Federal Regulations (CFR) Part 438 (primary care, adult and pediatric; OB/GYN; behavioral health [mental health and SUD providers]; specialist, adult and pediatric;). The number and type of physician specialties that are analyzed separately for application of the standards varies. Some states, like New Hampshire, focus on different specialty types from year to year; others have the specialty types written into the access standards. New Hampshire and New Jersey analyzed standards for a relatively high number of physician specialist types; Vermont recognized three specific types of specialists in addition to the six types listed in the regulations (cardiology, urology, and home health services), and Rhode Island applied its standards to the five specialists with the highest utilization each year, calculated separately for adult and pediatric specialists. Table 3-12 provides a comparison of the specialists designated by New Hampshire, Vermont, and New Jersey.

Table 3-12 Specialist Categories by State

Specialist Categories	New Hampshire	New Jersey	Vermont
Allergist	Yes	No	No
Cardiologist	Yes	Yes	Yes
Dermatologist	Yes	Yes	No
Endocrinologist	Yes	Yes	No
ENT/Otolaryngologist	Yes	Yes	No
Gastroenterologist	Yes	No	No
General Surgeon	No	Yes	No
Hematologist and Oncologist	Yes	Yes	No
Neurologist	Yes	Yes	No
OB/GYN	Yes	Yes	No
Ophthalmologist	Yes	Yes	No
Oral Surgeon	No	Yes	No
Orthopedist	Yes	Yes	No

[3-1] Like New Hampshire, Rhode Island specifies access standards in its Medicaid managed care contract, although there is only one statewide Medicaid managed care plan (MCP) and several specialty plans governing smaller populations. Vermont's Medicaid program is delivered through a Section 1115 waiver, and the Vermont Agency of Human Services serves as the single State agency for the Medicaid program, delegating responsibility for most services to the Department of Vermont Health Access (DVHA), a non-risk managed care-like model for service that imposes and calculates its own network adequacy standards. DVHA performs its annual GeoAccess analysis, which reflects actual utilization rather than standards.

Specialist Categories	New Hampshire	New Jersey	Vermont
Pulmonologist	Yes	No	No
Psychiatrist	No	Yes	No
SUD Provider	Yes	No	No
Urologist	Yes	Yes	Yes

All of the states considered set standards for the two facility types identified in 42 CFR Part 438; i.e., hospitals and pharmacies. Rhode Island also set access standards for ambulatory surgery centers and dialysis centers, and both Rhode Island and Vermont added standards for imaging facilities.

Enrollee Choice of PCP

New Hampshire is one of only two of the states considered (along with NJ), to build enrollee choice of PCPs into their access standard by requiring access to two providers within time and distance standards. The other states required access to only one provider within standards.

Ratio Standards

Two of the states examined require minimum provider-to-member ratios. New Jersey mandates no more than 2,000 members per PCP, which can be extended to 3,500 members when including NPs. Rhode Island mandates no more than 1,500 members to any single PCP and no more than 1,000 members to any single PCP within a PCP team. Like New Hampshire, Vermont does not currently have a ratio standard.

Time and Distance

For the most part, New Hampshire's standards fall in the middle of the range of times and distances permitted across the states. New Hampshire allows the longest drive time to PCPs (40 minutes), but that is paired with one of the shortest distances (15 miles). Notably, this is not directly comparable given that New Hampshire requires that each member have access to two providers within that standard. New Hampshire requires that a member have access to a hospital within 60 minutes or 45 miles, the most generous standard of any of the states considered. It also has the most generous standard for pediatric specialists, requiring access within 120 minutes or 80 miles.

The time and distance standards for the four states compared are presented in Table 3-13.

Table 3-13: Select Time and Distance Standards (Minutes or Miles) by State

Provider Type	New Hampshire	Rhode Island	Vermont	New Jersey
PCP	For 100 percent of members, access to	Adult and pediatric within 20 minutes or 20 miles	Shall not exceed 30 miles	Urban: Children and adults have access to 2 within

Provider Type	New Hampshire	Rhode Island	Vermont	New Jersey
	2 within 40 minutes or 15 miles			30 minutes or 6 miles; and 1 within 30 minutes or 2 miles, and 90% of members within 6 miles of 2 PCPs Non-urban: 85% of children and adults within 30 minutes* and 15 miles of 2 PCPs
OB/GYN	60 minutes or 45 miles	Within 45 minutes or 30 miles	Should not exceed 60 miles	90% of members within each county have 1 within lesser of 60 minutes or 45 miles
Specialist	Adult: 60 minutes or 45 miles Child: 120 minutes or 80 miles	Adult: Top 5 specialists within 30 minutes or 30 miles Child: Top 5 specialists within 45 minutes or 45 miles	Should not exceed 60 miles	Listed specialists: 90% of members in each county have 1 within lesser of 60 minutes or 45 miles. Unlisted specialists: 90% of members in each county have 1 within the lesser of 60 minutes driving time or 45 miles
Hospital	60 minutes or 45 miles	Within 45 minutes or 30 miles	Hospital within 30 minutes No more than 30 miles to ED	15 miles
Pharmacy	45 minutes or 15 miles	Within 10 minutes or 10 miles	Should not exceed 60 miles	No GeoAccess standard
Mental Health/ SUD	45 minutes or 25 miles	SUD Prescriber: within 30 minutes or 30 miles SUD Non-prescriber: within 20 minutes or 20 miles	Should not exceed 60 miles	No GeoAccess standard

*The distance expected to be traveled within 30 minutes varies with terrain, as described: for normal conditions/primary roads, 20 miles; for rural or mountainous areas, secondary routes, 20 miles; for flat areas or those connected with interstate highways, 25 miles; for those in metropolitan areas, 30 minutes by public transportation or no more than six miles.

Specifications for Determination of Travel Distance

Some of the comparison states provide very detailed specifications for calculation of time and distance. New Hampshire's standards are written in terms of "driving miles," indicating distances are to be calculated as encountered by drivers, rather than "as the crow flies." Vermont specifies the use of Geographic Information System (GIS) ArcGIS 10.4 to find the "least cost" route based on roadway time for trips. Rhode Island's DVHA generates its own GIS maps and charts that show the actual distances members are traveling to seek care. New Jersey sets one standard for travel time—30 minutes—but expects that different distances will be covered in that time in rural, urban, and metropolitan areas. For example, in metropolitan areas, the expectation is that 30 minutes of travel by public transit will equate to six miles.

4. Discussion

Conclusions

While the NAV process may be used to analyze different aspects of provider networks and members' access to care, the SFY 2023 NAV focused on network capacity and time-distance analyses for specified provider categories using member and provider data files that DHHS and each MCO submitted to HSAG.

For services that require members to travel to the provider (e.g., PCP visits), each MCO must ensure that it contracts with an adequate number of providers to meet specific time or distance network requirements. However, an MCO's failure to meet a time-distance standard does not necessarily reflect a network concern, as the MCO plan may have DHHS' approval to use alternate methods to ensure members' access to care (e.g., community services or telehealth). Additionally, an MCO's ability to meet the minimum network standard does not guarantee all facets of access to care for all members. Regardless of each MCO's ability to meet the established time-distance standards, the scope of the SFY 2023 NAV did not analyze other potential barriers members may encounter when attempting to access Medicaid services. For example, factors such as members' access to transportation, health status and needs related to disability accommodations, and appointment/service availability could account for inadequate access to care despite the SFY 2023 NAV results.

Overall, the New Hampshire SFY 2023 NAV results suggest that the MCOs have comprehensive provider networks, with some opportunities for improvement in certain geographic areas and for certain provider categories (e.g., pediatric specialists). New Hampshire's MCOs have generally contracted with a variety of providers to ensure that Medicaid/Children's Health Insurance Program (CHIP) members have access to a broad range of healthcare services within geographic time-distance standards.

For the network capacity analysis, the available data were not always sufficient to establish whether the MCOs met the standards required in the contract. Certain data issues HSAG encountered during its analysis inhibited gathering accurate data counts of the number of providers in the State or each region in total, or contracted by each MCO. Among these were barriers to establishing an accurate number of providers to use in measure denominators, as well as differences in MCO data practices that did not allow identification of all providers. These issues are discussed in the "Analytic Considerations" section and should be considered when determining how much weight to give the findings of the capacity analysis.

The comparative assessment of state adequacy standards revealed that DHHS' network adequacy time-distance standards fall well within the range of those adopted in the comparison states. New Hampshire falls well within the range of time-distance standards for OB/GYN, adult specialist, and mental health providers. Its longer distance standard for PCPs is justified at least in part by the standard requiring access to two providers, rather than the single PCP covered by most of the other states considered. However, DHHS permitted the longest drive time and distance to pediatric specialists and hospitals

when compared to the other states. HSAG recommends that DHHS consider whether it should lower the drive time and distance standards for either of these provider types. The comparison states use different standards in urban and rural areas, and/or set different expectations for the percentage of members required to have access to adjust their standards to realistically serve their populations.

To model Rhode Island and Vermont practices, DHHS might also consider whether to set additional access standards for provider specialties or facilities such as imaging or dialysis facilities based on members' needs.

In addition, DHHS could consider strengthening its time-distance standards by specifying assumptions to be made in geospatial analysis. For example, New Jersey's Division of Medical Assistance and Health Services uses a general standard of access of within 30 minutes but explains how the standard is expected to equate to different mileage depending on where members reside and their likely mode of transportation. In metropolitan areas, that means six miles or 30 minutes travel time on public transit; in rural or mountainous areas served only by secondary routes, that means 20 miles; in flat areas served by interstate highways, that means 25 miles.

Analytic Considerations

Various factors associated with the SFY 2023 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:

- NAV results do not reflect any MCO network changes implemented since December 1, 2022.
- For each of five provider categories related to SUD treatment, DHHS has set contractual standards for MCOs with respect to the percentage of all providers "licensed and practicing in New Hampshire" (or in one instance, the percentage of "willing" providers in New Hampshire) that must be included in their networks, and the number of providers that must be included in their network within each region. The network capacity analysis is intended to measure the extent to which MCOs are able to meet these standards. In most of these categories, it is likely that some of the State's licensed and practicing providers are not contracted with any MCO, hence auxiliary information—provider lists—from sources such as the State licensing board and SAMHSA are necessary to enumerate the provider population. DHHS provided such lists for MLADCs, OTPs, residential SUD treatment programs, and peer recovery organizations and pointed HSAG to additional federal sources for information on buprenorphine prescribers and residential treatment centers. DHHS does not maintain these lists, and issues with the lists could easily lead to under- or overcounting the total provider population at the State or region level. For example, DHHS provided HSAG with a link to the SAMHSA list of buprenorphine prescribers on 11/07/2022. DHHS acknowledges that with subsequent changes to federal reporting requirements, the list may no longer represent a complete list of all buprenorphine prescribers in the State.
- The lists were also used to help identify providers in MCO-submitted data. They were not developed for this use, however, and some lacked basic data elements necessary to allow HSAG to reliably

match providers in those sources with providers in the MCO network data. For example, none of the MCOs specifically identified buprenorphine prescribers in their data. The buprenorphine prescriber list, on the other hand, included provider names but did not include standard healthcare provider identifiers such as NPI or Medicaid Provider ID. This likely affected the accuracy of matching list items to MCO provider data. HSAG encountered similar issues across all five provider categories. As noted above, potential issues with provider lists for identifying the total and regional population of providers, and known issues with provider lists for identifying network providers that belong to these provider categories, should be considered when evaluating and interpreting capacity analysis results.

- The MCOs must demonstrate that their members have access to specific types of healthcare providers within the minimum time-distance standards to be compliant with the network contract requirements. However, an MCO's failure to meet a geographic access standard must be evaluated in the context of other circumstances such as what other MCOs are able to achieve and whether the MCO has alternate methods of ensuring members' access to care (e.g., the use of telehealth or mail-order pharmacy services).
- The NAV findings are based on the MCOs' network data files for all providers active with each MCO as of December 1, 2022, and are contingent on the quality of member data and provider network data supplied by DHHS and the MCOs, respectively. Any substantial or systematic errors in the member or provider network data may compromise the validity and reliability of the SFY 2023 NAV results, including the following detailed considerations:
  - HSAG used the MCOs' SFY 2023 network data to assign providers to provider categories, informed by provider crosswalks created by the HSAG Survey Team in collaboration with DHHS in 2021 and 2022. However, the MCOs' submission of provider type and provider specialty information was not standardized, which complicated the classification of providers into the categories targeted for the time-distance analysis. Some of what appeared to be a lack of compliance identified during the NAV analyses may reflect the MCOs' different approaches to aligning internal network data with the network adequacy standard categories. For example, **WS** acknowledged that peer recovery services were not tracked in their provider data. HSAG mitigated this concern by thoroughly reviewing all provider data fields, including provider type, provider specialty, provider degree, and provider taxonomy codes to ensure the correct classification of provider categories. However, if data were incomplete or non-specific, HSAG may not have been able to appropriately classify all providers to the correct category.
  - HSAG's NAV analyses used members' residential addresses and provider network service addresses as supplied in the DHHS and MCOs' data, and addresses may not have reflected all members' actual place of residence or all providers' service locations on December 1, 2022, due to natural movement of residents and places of business and the frequency of updates to the data.
  - Prior to calculating time-distance results, HSAG geocoded the MCOs' provider network address data and DHHS member address data using Quest Analytics Suite software to assign latitude and longitude values to each record. A small number of records could not be geocoded and were subsequently excluded from NAV analyses. For a larger but still small proportion of records, Quest was unable to geocode addresses without modification; HSAG made minor adjustments to some addresses and geocoded the most problematic addresses using a "ZIP distributive" method

that places longitude and latitude at randomly determined locations proximate to population concentrations within the provided ZIP Code.

- The time-distance calculations reflected in SFY 2023 NAV represent a high-level measurement of geographic distribution of network provider locations relative to members. These statistics should be interpreted in the context of other information such as whether the provider's panel is accepting new patients at a specific location or how active the network location is in the program.

Recommendations

DHHS Recommendations

Based on the results and conclusions presented in this report, HSAG recommends the following for DHHS:

- Due to the challenges surrounding quantifying the statewide denominators for SUD providers and assigning providers to public health regions, HSAG recommends that the network capacity analysis be considered for information only at this point, not as an indication that MCOs met (or failed to meet) particular standards.
- For SUD categories that DHHS is scrutinizing carefully in a capacity analysis, DHHS should work with the MCOs and other agencies to create and maintain a list of licensed, practicing and "willing" (where applicable) providers. In addition to using this list for analyses, MCOs could also use it to remain aware of the full range of potential contracting partners, which is especially critical where DHHS expects contracting with 100 percent of providers (i.e., willing peer recovery programs). To be most helpful, such lists should contain necessary identifying information including provider NPIs (or other distinguishing identification numbers), designations for individual and group providers, and addresses for all locations where services are provided. This information will allow the MCOs to ensure they are meeting both the required statewide and regional standards.
- DHHS should work with HSAG and the MCOs to improve the quality of reported data. This could include requiring MCOs to collect and maintain New Hampshire Medicaid provider type and specialty codes as defined in the Provider Billing Manual or collaborating with the MCOs to create and use a standardized approach (i.e., provider crosswalk) to classify provider categories for NAV activities. DHHS could encourage MCOs to carefully distinguish between individual and organizational/facility records for provider types that include both individual and organizational/facility providers. As an example, a record for an individual physician working in a group practice should have an individual provider type, an individual provider specialty, and an individual-level taxonomy.
- DHHS may consider conducting an in-depth review of provider categories for which each MCO did not meet the geographic access standards, with the goal of determining whether or not the failure of the MCO to meet the standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area. Based on the findings of this review, DHHS may consider adjusting the geographic access standards or setting different standards based on urbanicity. Future

analyses should evaluate the extent to which the MCOs have requested exemptions from DHHS for provider categories for which providers may not be available or willing to contract with the MCOs.

- 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 the care they have received.
- DHHS may consider collaborating with HSAG to design and implement a focus study to investigate selected topics regarding access to care among Medicaid members by geographic region. Depending on available resources, study topics may include evaluating health disparities affecting access to care or the potential for in-network providers who are not providing services to Medicaid members (i.e., phantom provider network assessment).

MCO Recommendations

MCO-specific appendices C through F reflect MCO-specific recommendations. In general, based on the results and conclusions presented in this report, HSAG recommends that the MCOs consider the following to strengthen provider networks and ensure members' timely access to healthcare providers:

- For the provider categories for which each MCO did not meet the time-distance standard, the MCO should assess whether this is due to a lack of providers available for contracting in the area, a lack of providers willing to contract with the MCO, the inability to identify the providers in the data, or other reasons.
- MCOs should continue to monitor processes for creating the provider network data files and review the file for accuracy prior to submitting it to HSAG.

Appendix A. Methodology

Data

DHHS and the MCOs provided Medicaid member demographic information and provider network files to HSAG for use in the analyses. HSAG submitted detailed data requirements documents to DHHS and the MCOs requesting data which met the following criteria:

Member demographic data as of December 1, 2022:

- Member eligibility and enrollment data including start and end dates for enrollment with the MCO.
- The MCO's network contracted provider data including provider specialties and service locations as of December 1, 2022.

DHHS provided auxiliary information necessary to classify providers into the specialized categories featured in the network capacity analyses as follows:

- MLADCs: a list from the New Hampshire Office of Professional Licensure and Certification (OPLC)
- OTPs
- Residential SUD treatment programs
- Willing peer recovery programs

In agreement with DHHS, HSAG also downloaded additional information on buprenorphine prescribers, OTPs, and residential SUD treatment programs from SAMHSA.[A-1,A-2]

Data Processing

HSAG cleaned, processed, and used the data submitted to define unique lists of providers, provider locations, and members for inclusion in the analyses. HSAG standardized and geocoded all Medicaid member and provider addresses using Quest Analytics Suite software. Analyses for pediatric specialists were limited to members younger than 18 years of age, and analyses for adult specialists were limited to members 18 years of age and older. Analyses for OB/GYN providers were limited to female members

A-1 SAMHSA Opioid Treatment Program Directory. Available at: https://dpt2.samhsa.gov/treatment/directory.aspx, Accessed on: Apr 25, 2023.

A-2 SAMHSA Buprenorphine Practitioner Locator. Available at: https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator. Accessed on: Apr 25, 2023.

ages 13 years and older. The analysis for NICU providers was limited to female members ages 15 to 49 years old.

Contracted provider locations in the State of New Hampshire and in neighboring states (Massachusetts, Maine, Vermont, New York, Connecticut, and Rhode Island) were included in time-distance analyses. All locations associated with a given provider were included in the analyses. For example, if a single provider practiced at three locations, each location was considered a unique location for the analyses.

Network Adequacy Validation (NAV) Analysis

Network Capacity Analysis

Table A-1 shows the provider categories included in the network capacity analysis and the network access standards.

Table A-1—Provider Capacity Standards

Provider Category/Service	Requirement
Master Licensed Alcohol and Drug Counselors (MLADCs)[1]	The MCO Participating Provider Network shall include seventy percent (70%) of all such providers licensed and practicing in New Hampshire and no less than two (2) providers in any public health region unless there are less than two (2) such providers in the region.
Opioid Treatment Programs (OTPs)[2]	The MCO Participating Provider Network shall include seventy-five percent (75%) of all such providers licensed and practicing in New Hampshire and no less than two (2) providers in any public health region unless there are less than two (2) such providers in the region.
Buprenorphine Prescribers[3]	The Network shall include seventy-five percent (75%) of all such providers licensed and practicing in New Hampshire and no less than two (2) providers in any public health region unless there are less than two (2) such providers in the region.
Residential SUD Treatment Programs[4]	The Network shall include fifty percent (50%) of all such providers licensed and practicing in New Hampshire and no less than two (2) providers in any public health region unless there are less than two (2) such providers in the region.
Peer Recovery Programs[5]	The MCO's Participating Provider Network shall include one hundred percent (100%) of all such willing programs in New Hampshire.

[1] DHHS provided a list of licensed and practicing MLADCs in the State using State licensure files. HSAG also identified MLADCs in the provider data submitted by MCOs using New Hampshire Medicaid Provider Type Codes 220 and 221 and provider specialty and taxonomy information.

[2] DHHS provided a list of licensed and practicing OTPs. HSAG supplemented that list with OTPs identified in the MCOs' provider data and providers identified by SAMHSA.

[3] HSAG obtained a list of buprenorphine prescribers from SAMHSA, through a link provided by DHHS on 11/07/2022. While accurate at that time, DHHS acknowledges there have been subsequent changes to federal reporting requirements that are not reflected in the list.[4] DHHS provided a list of licensed and practicing residential SUD treatment programs. HSAG identified additional programs in MCO data using New Hampshire Medicaid Provider Type Code 223 and providers identified by SAMHSA.

[5] DHHS provided the State-Funded Recovery Community Organizations in New Hampshire guide from the New Hampshire Bureau of Drug & Alcohol Services dated August 2022. HSAG identified additional programs in MCO data using New Hampshire Medicaid Provider Type Code 228 and provider type, specialty, and taxonomy information.

For the statewide analysis, HSAG used the lists provided by DHHS supplemented with information from the MCOs and from SAMHSA to estimate the total number of providers in each category licensed and practicing in New Hampshire, including providers from State and SAMHSA lists that were not found in the MCO-submitted data. For the regional analysis, provider addresses were mapped to New Hampshire's public health regions using a crosswalk provided by DHHS. The total number of providers in each category was calculated for each region for use in determining whether each MCO met the regional standard.

Geographic Network Distribution Analysis

Table A-2 shows the provider categories included in the time-distance analyses, the member criteria for inclusion in populations for the analyses as required, and the network access standards. New Hampshire requires that MCOs ensure that all members (100 percent) in each county of the contracting area have access within the stated time or distance standard for each provider category.

HSAG used Quest Analytics software to calculate the travel time or physical distance between the addresses of members and the addresses of their nearest three providers for all provider categories identified in the analysis. All study results were stratified by MCO, as well as by county.

Table A-2 shows DHHS' access standards by provider category. These standards were used to assess MCO compliance. Please note that aside from the New Hampshire Medicaid provider type code, the submitted provider type and provider specialty information was not standardized across MCOs. In addition, while all provider records from **NHHF** included valid New Hampshire Medicaid provider type codes, as did nearly all records from **ACNH** (99.8 percent), well under one-third of **WS** records (29.5 percent) included New Hampshire Medicaid provider type codes that were present and valid. These and other features of the data required detailed review of provider records, including reference to standard taxonomy codes and to the MCO-defined provider type and provider specialty fields. In reviewing these categories, HSAG used classifications previously made for network validation surveys that HSAG conducted for DHHS.

Table A-2—Provider Categories and Time-Distance Standards

Provider/Service	Requirement
Adult and Pediatric PCPs[1]	Two (2) within forty (40) driving minutes or fifteen (15) driving miles
Adult Specialists[2]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Pediatric Specialists[2]	One (1) within one hundred twenty (120) driving minutes or eighty (80) driving miles
OB/GYN Providers[2]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospitals	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Adult and Pediatric Mental Health Providers[3]	One (1) within forty-five (45) driving minutes or twenty-five (25) driving miles
Pharmacies	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles
Tertiary or Specialized Services (Trauma, Neonatal)[4]	One (1) within one hundred twenty (120) driving minutes or eighty (80) driving miles
Individual/Group MLADCs[5]	One (1) within forty-five (45) driving minutes or fifteen (15) driving miles
SUD Programs[6]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Adult Medical Day Care[7]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Hospice[8]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles
Office-Based PT/OT/ST[9]	One (1) within sixty (60) driving minutes or forty-five (45) driving miles

[1] PCPs included, but were not limited to, pediatricians, family practitioners, general practitioners, internists, physician assistants (under the supervision of a physician), or ARNPs, as designated by the MCO.

[2] Specialists included allergists, cardiologists, dermatologists, endocrinologists, otolaryngologists (ENTs), gastroenterologists, hematologists and oncologists, neurologists, OB/GYNs, ophthalmologists, orthopedists, pulmonologists, SUD providers, and urologists. OB/GYN providers included physicians, NPs, and/or women's health specialists offering prenatal care services (e.g., nurse midwives).

[3] Mental health providers included physicians, psychologists, psychiatrists, psychiatric NPs, and licensed counselors excluding those who specialize in providing SUD services, and including but not limited to New Hampshire Medicaid Provider Type Codes 002, 009, 042, 093, 208, 220, 221, 225, 226, 229 and 230.

[4] Hospitals that provide tertiary or specialized services were defined as those designated level I or level II trauma centers according to American College of Surgeons (ACS) criteria, and those with a designated level III or level IV NICU.

[5] MLADCs included Master Level Alcohol and Drug Counselors licensed by the New Hampshire Board of Medicine, and including but not limited to those identified by New Hampshire Medicaid Provider Type Codes 220 and 221.

[6] SUD programs included providers delivering SUD-related services as identified by provider type, specialty codes, and taxonomy codes and New Hampshire Medicaid Provider Type Codes 222 and 223 where provided.

[7] Adult medical day care providers included but were not limited to those identified with New Hampshire Medicaid Provider Type Code 058.

[8] Hospice providers included but were not limited to those identified with New Hampshire Medicaid Provider Type Code 006, and were limited to agencies or facilities.

[9] Office-based PT/OT/ST providers included but were not limited to those identified with New Hampshire Medicaid Provider Type Codes 039, 040, 041, 206, 207 and 209.

Comparative Assessment of State Standards

HSAG selected Rhode Island and Vermont from the New England Division of the U.S. Census Bureau, the same division containing New Hampshire, and New Jersey from the Middle Atlantic Division as

suitable states for comparison due to similarities in population size, density, geography, or approach to standards. Although the underlying structure of these states' Medicaid plans often differs from New Hampshire's structure in important respects, all have network adequacy standards similar to those used in New Hampshire.[A-3]

Several New England Division state populations were around the same or less than New Hampshire's 1.4 million in 2021. HSAG selected Rhode Island, with 1.1 million residents, and Vermont, with 0.65 million residents (as of 2021).[A-4] These states are both broadly similar in geography with a mixture of urban and rural areas. Vermont, like New Hampshire, includes large areas of mountainous, sparsely populated terrain. HSAG also looked at Middle Atlantic Division states, which generally had much larger populations than New Hampshire. New Jersey was selected for comparison, however, because it provided a good example of access standards tailored to a variety of geographies and levels of urbanicity.

HSAG obtained publicly available documents and examined the selected states' most recent Medicaid managed care contracts, EQRO technical reports, and/or quality strategies for their network adequacy standards, which HSAG then systematically compared. [A-5,A-6,A-7]

A-3 Like New Hampshire, Rhode Island specifies access standards in its Medicaid managed care contract, although there is only one statewide Medicaid MCP and several specialty plans governing smaller populations. Vermont's Medicaid program is delivered through a Section 1115 waiver, and the Vermont Agency of Human Services serves as the single State agency for the Medicaid program, delegating responsibility for most services to the DVHA, a non-risk managed care-like model for service that imposes and calculates its own network adequacy standards.

A-4 USAFacts. Our Changing Population. Available at: https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/pennsylvania?endDate=2021-01-01&startDate=2010-01-01. Accessed on: Apr 24, 2023.

A-5 Rhode Island Medicaid Managed Care Program UnitedHealthcare Community Plan of Rhode Island, 2020 External Quality Review Annual Technical Report, published April 2022. Available at: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-04/RI%202020%20EQR%20Annual%20Techical%20Report%20for%20Neighborhood%20Health%20Plan%20-%20Final.pdf. Accessed on: Apr 24, 2023.

A-6 Access to Care Plan Department of Vermont Health Access, March 18, 2022. Available at: https://dvha.vermont.gov/sites/dvha/files/doc_library/Access%20to%20Care%20Plan%202022.pdf. Accessed on: Apr 24, 2023.

A-7 New Jersey Department of Human Services Division of Medical Assistance and Health Services. Division of Medical Assistance and Health Services Quality Strategy, updated June 2014. Available at: https://www.nj.gov/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf. Accessed on: Apr 24, 2023.

Appendix B. HSAG Network Adequacy Validation Team

The HSAG NAV team was assembled based on the full complement of skills required for the design and implementation of the network adequacy validation. Table B-1 lists the key NAV team members, their roles, and relevant skills and expertise.

Table B-1—Key HSAG Staff for the SFY 2023 NAV

Name/Role	Skills and Expertise
Leslie Arendell, MS *Director, Data Science & Advanced Analytics*	Ms. Arendell has more than 20 years of experience working in epidemiological research and data analysis, with expertise in study design, analysis planning, statistical analysis, report writing, and Medicare and Medicaid programs and data systems. In support of HSAG's external quality review (EQR) contracts, Ms. Arendell has conducted network analysis studies for 10 states. These studies have involved a variety of network adequacy methods including time and distance geographic assessments, provider-to-member ratio calculations, phantom provider network assessments, appointment availability surveys to assess member wait times, and provider network disruption analysis. Ms. Arendell has been employed by HSAG for 10 years and has been involved in EQR services in New Hampshire since 2022.
Cindy Strickland, JD, BS *Associate Director, Data Science & Advanced Analytics*	Ms. Strickland has over 10 years of healthcare industry experience leading, managing, and coordinating analytic activities for network adequacy evaluations, EQR focus studies, waiver evaluations, and other research and writing in support of HSAG's contracts with state and federal partners including the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Organization Privacy Protection Center (PSOPPC) and the National Patient Safety Database (NPSD); and the New Hampshire Premium Assistance Program (PAP) Evaluation Plan Implementation, Summative Evaluation Report. Ms. Strickland has been employed by HSAG for 10 years and has been involved in evaluating network adequacy since 2019.

Name/Role	Skills and Expertise
Michael Lichter, PhD *Senior Analyst, Data Science & Advanced Analytics*	Dr. Lichter has more than 20 years of experience designing, conducting, and reporting on analyses of quantitative and qualitative social research and evaluation, including more than 10 years of experience in healthcare research. As an employee of HSAG since 2014, Dr. Lichter has conducted numerous analytic activities regarding healthcare access, quality, and safety for federal and state clients. Dr. Lichter has been contributing to studies regarding network adequacy since 2019.
Joe Mireles, MPH *Analyst III, Data Science & Advanced Analytics*	Mr. Mireles has more than 17 years of experience in healthcare, with expertise in research, informatics, data collection and analysis, and reporting. Mr. Mireles has been employed by HSAG for six years and has been involved in EQR services in New Hampshire since 2022.
Adrianna Ancillo, BS *Analytics Coordinator III, Data Science & Advanced Analytics*	Ms. Ancillo has nine years of healthcare industry experience in direct patient care, coordinating and supporting analytic activities. Ms. Ancillo has been with HSAG for six months and has been involved in EQR services in New Hampshire since 2022.

Appendix C. Detailed Results for ACNH

Network Capacity Analysis

ACNH met both statewide and regional network capacity standards for only one SUD provider category: OTPs. Additionally, **ACNH** met the statewide standard for residential SUD treatment programs, and the regional requirement for MLADCs and buprenorphine prescribers. **ACNH** did not meet the regional standard for residential SUD treatment programs and failed to meet the required number of providers per region in eight of the 13 public health regions.[C-1]

Table C-1 displays those SUD provider capacity standards for which **ACNH** did not meet the regional requirement, and identifies the specific public health regions where **ACNH** did not meet the standard.

Table C-1—ACNH Public Health Regions Not Meeting the Statewide Provider Capacity Standards

Provider Category	Regions Not Meeting the Required Number of Providers per Region*
Residential SUD Treatment Programs	Capital, Central New Hampshire, Greater Nashua, Greater Sullivan, North Country, Seacoast, Upper Valley, and Winnipesaukee

*Two providers are required in any public health region unless there are less than two providers in the region. No per-region requirement for peer recovery programs.

Geographic Network Distribution Analysis

Adherence to Time-Distance Standards

Table C-2 displays where **ACNH** did not meet the minimum geographic access standards in a specific county for each applicable provider category.

Table C-2—ACNH Counties Not Meeting Time-Distance Standards by Provider Category

Provider Category	Counties Not Meeting the Standard*
Allergist, Adult	Carroll (83.8%), Coos (0.0%), Grafton (87.1%)
Allergist, Pediatric	Belknap (46.3%), Carroll (2.1%), Cheshire (88.4%), Coos (0.0%), Grafton (0.0%), Merrimack (91.0%), Strafford (99.8%), Sullivan (0.2%)
Dermatologist, Adult	Coos (95.8%)
Dermatologist, Pediatric	Coos (99.3%)

[C-1] Table 3-1 through Table 3-5.

Provider Category	Counties Not Meeting the Standard*
Endocrinologist, Adult	Coos (85.2%)
Hematologists and Oncologists, Pediatric	Coos (99.3%)
Neurologist, Pediatric	Coos (99.3%)
Ophthalmologist, Adult	Coos (27.2%)
Ophthalmologist, Pediatric	Belknap (0.0%), Carroll (0.0%), Cheshire (0.0%), Coos (0.0%), Grafton (0.0%), Hillsborough (0.0%), Merrimack (0.0%), Rockingham (0.0%), Strafford (0.0%), Sullivan (0.0%)
Orthopedist, Pediatric	Coos (99.3%)
Otolaryngologist, Pediatric	Coos (99.3%)
Tertiary or Specialized Services: Level I or Level II Trauma Centers	Coos (98.8%)
Tertiary or Specialized Services: Level III or Level IV NICU	Coos (99.3%)
Mental Health Providers, Pediatric	Coos (98.9%)
Adult Medical Day Care	Coos (83.5%), Grafton (99.5%)
Hospice	Coos (96.9%)
OT	Coos (99.9%)
ST	Coos (96.2%)

*Rows are only shown if at least one county did not meet the standard.

Some **ACNH** members living in Coos County did not have access within standards for 18 of the provider categories assessed. No members in Coos County had access within standards for adult and pediatric allergists and pediatric ophthalmologists. Members living in eight counties did not have access within standards to a pediatric allergist. No members in 10 counties had access within standards to a pediatric ophthalmologist.

Appendix D. Detailed Results for NHHF

Network Capacity Analysis

NHHF met both statewide and regional network capacity standards for only one SUD provider category: OTPs. **NHHF** also met the State standard for residential SUD treatment programs. **NHHF** met regional standards for buprenorphine prescribers but failed to meet the regional standards for MLADCs (lacking sufficient providers in one of 13 public health regions) and residential SUD treatment programs (lacking sufficient providers in eight of the 13 public health regions).

Table D-1 displays those SUD provider capacity standards that **NHHF** did not meet, and identifies specific public health regions where **NHHF** did not contract with the required minimum number of providers for each applicable provider category.

Table D-1—NHHF Public Health Regions Not Meeting the Statewide Provider Capacity Standards

Provider Category	Regions Not Meeting the Required Number of Providers per Region*
MLADCs	Central New Hampshire
Residential SUD Treatment Programs	Capital, Central New Hampshire, Greater Nashua, Greater Sullivan, North Country, Seacoast, Upper Valley, and Winnipesaukee

*Two providers in any public health region unless there are less than two providers in the region. No per-region requirement for Peer Recovery Programs.

Geographic Network Distribution Analysis

Adherence to Time-Distance Standards

Table D-2 displays where **NHHF** did not meet the minimum geographic access standards in a specific county for each applicable provider category.

Table D-2—NHHF Counties Not Meeting Time-Distance Standards by Provider Category

Provider Category	Counties Not Meeting the Standard*
Allergist, Adult	Carroll (54.3%), Coos (0.0%), Grafton (85.1%)
Allergist, Pediatric	Coos (98.4%)
Cardiologist, Adult	Coos (80.2%)
Dermatologist, Adult	Coos (94.2%)
Dermatologist, Pediatric	Coos (98.4%)
Endocrinologist, Adult	Coos (82.1%)
Endocrinologist, Pediatric	Coos (98.5%)
Gastroenterologist, Pediatric	Coos (98.4%)
Hematologists and Oncologists, Pediatric	Coos (98.4%)
Ophthalmologist, Pediatric	Coos (23.8%)
Orthopedist, Pediatric	Coos (98.4%)
Otolaryngologist, Pediatric	Cheshire (98.7%)
Pulmonologist, Pediatric	Coos (98.4%)
SUD Providers, Adult[1]	Coos (95.2%)
Urologist, Pediatric	Coos (98.4%)
Tertiary or Specialized Services: Level III or Level IV NICU	Coos (88.2%)
Mental Health Providers, Pediatric	Coos (83.3%)
Individual/Group MLADCs[2]	Coos (83.5%)
Adult Medical Day Care	Coos (78.3%), Grafton (95.8%)
Hospice	Coos (95.2%)
ST	Coos (94.3%)

*Rows are only shown if at least one county did not meet the standard.
[1]There was no distinction in plan data between SUD providers who serve pediatric or adult members, so the entire population of SUD providers was used to calculate access to pediatric and adult populations.
[2]No group MLADCs were identified in plan data, so all MLADCs are individual providers.

Some **NHHF** members living in Coos County did not have access within standards for 20 of the provider categories assessed. No members in Coos County had access within standards to an adult allergist, and only 23.8 percent of members in Coos County had access within standards to a pediatric ophthalmologist. Outside Coos County, for most of the counties where **NHHF** did not meet standards, member access

percentages ranged from a low of 54.3 percent of Carroll County members having access to an adult allergist to several provider types and counties with member access in excess of 80 percent or 90 percent.

Appendix E. Detailed Results for WS

Network Capacity Analysis

WS was the only MCO that did not meet network capacity standards for OTP, being unable to contract with the required percentage of statewide providers or the minimum number in several public health regions. The MCO met the State requirement for one provider category—residential SUD treatment programs. For each of three provider categories—MLADCs, OTPs, and residential SUD treatment programs—WS did not meet the regional requirement in at least three of 13 public health regions. The specific regions where WS did not meet requirements varied across the provider categories. In the Central New Hampshire region, WS did not meet requirements for MLADCs or residential SUD treatment programs, and in the South Central region, WS did not meet requirements for OTPs or residential SUD treatment programs. Table E-1 displays those SUD provider capacity standards that WS did not meet and identifies specific public health regions where WS did not contract with the required minimum number of providers for each applicable provider category.

Table E-1—WS Public Health Regions Not Meeting the Statewide Provider Capacity Standards

Provider Category	Regions Not Meeting the Required Number of Providers per Region*
MLADCs	Central New Hampshire, Greater Nashua, and Upper Valley
OTPs	Seacoast, South Central, and Winnipesaukee
Residential SUD Treatment Programs	Carroll County, Central New Hampshire, North Country, and South Central

*Two providers in any public health region unless there are less than two providers in the region. No per-region requirement for Peer Recovery Programs.

Geographic Network Distribution Analysis

Adherence to Time-Distance Standards

Table E-2 displays where WS did not meet the minimum geographic access standards in a specific county for each applicable provider category.

Table E-2—WS Counties Not Meeting Time-Distance Standards by Provider Category

Provider Category	Counties Not Meeting the Standard*
Allergist, Adult	Carroll (88.4%), Coos (0.0%), Grafton (82.1%)
Allergist, Pediatric	Coos (89.1%)
Cardiologist, Adult	Coos (85.8%)

Provider Category	Counties Not Meeting the Standard*
Dermatologist, Adult	Coos (96.2%)
Dermatologist, Pediatric	Coos (97.8%)
Endocrinologist, Adult	Coos (87.8%)
Endocrinologist, Pediatric	Coos (98.0%)
Gastroenterologist, Pediatric	Coos (97.8%)
Hematologists and Oncologists, Pediatric	Coos (97.8%)
Neurologist, Pediatric	Coos (97.8%)
Ophthalmologist, Pediatric	Belknap (0.0%), Carroll (0.0%), Cheshire (0.0%), Coos (0.0%), Grafton (0.0%), Hillsborough (0.0%), Merrimack (0.0%), Rockingham (0.0%), Strafford (0.0%), Sullivan (0.0%)
Orthopedist, Pediatric	Coos (97.8%)
Otolaryngologist, Pediatric	Carroll (73.4%), Coos (0.0%), Grafton (45.3%), Sullivan (99.7%)
Pulmonologist, Pediatric	Coos (97.8%)
Urologist, Pediatric	Coos (97.8%)
Tertiary or Specialized Services: Level I or Level II Trauma Centers	Coos (88.3%)
Tertiary or Specialized Services: Level III or Level IV NICU	Coos (86.6%), Grafton (99.5%)
Mental Health Providers, Adult	Coos (98.4%)
Mental Health Providers, Pediatric	Coos (62.5%)
Individual/Group MLADCs[1]	Coos (96.1%)
Adult Medical Day Care	Coos (83.9%), Grafton (97.1%)
Hospice	Coos (96.1%)

*Rows are only shown if at least one county did not meet the standard.
[1]No group MLADCs were identified in plan data, so all MLADCs are individual providers.

Some **WS** members living in Coos County did not have access within standards for 22 of the provider categories assessed. Some **WS** members in Carroll and Grafton counties also lacked access to adult allergists, pediatric ophthalmologists, and pediatric otolaryngologists. No **WS** members in 10 counties had access within standards to a pediatric ophthalmologist.

Appendix F. MCO Recommendations Requiring Follow-Up

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

ACNH

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

Table F-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-2023-EQRO.01_NA-01	ACNH should maintain current levels of access to care and continue to address network gaps for the following: • Seek additional SUD providers for the following categories to meet State and regional standards: MLADCs, residential SUD treatment programs. • Find alternative access options for residents in Coos County. • Seek additional pediatric allergists and pediatric ophthalmologists in counties where access standards were not met.
2	ACNH-2023-EQRO.01_NA-02	ACNH should continue to monitor its processes for creating the provider network data files and review the file for accuracy prior to submitting it to HSAG, particularly with respect to identifying pediatric specialists and residential SUD treatment programs.

NHHF

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

Table F-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-2023-EQRO.01_NA-01	NHHF should maintain current levels of access to care and continue to address network gaps for the following:

NHHF EQRO Findings/Recommendations for Improvement to Include in the EQRO.01 Report		
NAV Report		
		• Seek additional SUD providers for the following categories to meet State and regional standards: MLADCs and residential SUD treatment programs. • Find alternative access options for residents in Coos County.
2	NHHF-2023-EQRO.01_NA-02	NHHF should continue to monitor its processes for creating the provider network data files and review the file for accuracy prior to submitting it to HSAG.

WS

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

Table F-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-2023-EQRO.01_NA-01	WS should maintain current levels of access to care and continue to address network gaps for the following: • Seek additional SUD providers for the following categories to meet State and regional standards: MLADCs, OTPs and residential SUD treatment programs. • Find alternative access options for residents in Coos County. • Seek additional pediatric ophthalmologists in counties where access standards were not met.
2	WS-2023-EQRO.01_NA-02	WS should continue to monitor its processes for creating the provider network data files and review the file for accuracy prior to submitting it to HSAG.