State of New Hampshire Department of Health and Human Services

State Fiscal Year 2025 Network Adequacy Validation Report

October 2025

—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) 2025 network adequacy validation (NAV) has a conflict of interest with the following Managed Care Entities (MCEs): **AmeriHealth Caritas New Hampshire** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), **WellSense Health Plan** (**WS**), and Delta Dental Plan of New Hampshire, Inc. DBA **NorthEast Delta Dental** and the plan administrator, **DentaQuest** (**NEDD/DQ**).

1. Executive Summary

Introduction

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

DHHS' EQRO, Health Services Advisory Group, Inc. (HSAG), conducted the SFY 2025 NAV, assessing the accuracy of the state-defined network adequacy indicators that the MCEs reported. HSAG evaluated the collection, reliability, and validity of provider and network adequacy data, and the methodologies, systems, and processes the MCEs used to calculate and report indicators of network adequacy. HSAG used a CMS-suggested methodology to determine an overall validation rating for each indicator which reflects HSAG's overall confidence that each MCE used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators set by DHHS.

The SFY 2025 NAV activity included three Managed Care Organizations (MCOs) and one Dental Organization (DO):

- **AmeriHealth Caritas New Hampshire** (**ACNH**)
- **New Hampshire Healthy Families** (**NHHF**)
- **WellSense Health Plan** (**WS**)
- Delta Dental Plan of New Hampshire, Inc. DBA **NorthEast Delta Dental** (**NEDD**) and the plan administrator, **DentaQuest** (**DQ**)

HSAG performed the following activities during the SFY 2025 NAV:

1. Defined the scope of the validation of the quantitative network adequacy standards.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: July 17, 2025.

a. Obtained needed information from the State.
b. Identified and defined network adequacy standards applicable to the MCEs for validation.
c. Identified and defined provider types subject to standards.
d. Established the timeline for activities.

2. Identified data sources for validation and asked any clarifying questions regarding sources.
3. Reviewed the information systems underlying the MCEs' network adequacy monitoring.
   a. Developed NAV study materials, an Information Systems Capabilities Assessment Tool (ISCAT), and a document request packet (DRP).
   b. Reviewed each MCE's completed ISCAT and submitted documents.
   c. Assessed processes for collecting network adequacy data not addressed in the ISCAT.
4. Validated network adequacy assessment data, methods, and results.
   a. Assessed the reliability and validity of MCE network adequacy data, methods, and results.
   b. Calculated validation ratings, including an independent calculation of the network adequacy indicators.
   c. Summarized validation findings.
5. Communicated preliminary findings to each MCE.
6. Generated the annual network adequacy report.

Methodology

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

HSAG conducted the following activities during SFY 2025:

- **Information systems capabilities assessment (ISCA)**: In accordance with the CMS EQR Protocol 4, HSAG conducted a desk review of materials that the MCEs submitted, supplemented with live virtual review sessions demonstrating the information systems, data processing procedures, and underlying methodology that the MCEs utilized to support their network adequacy indicator reporting.
- **Time and distance analysis**: New Hampshire requires MCEs to meet geographic access standards by providing access to a minimum number of network providers within a minimum driving distance or driving time from members' residences.[2] These standards apply to a broad range of provider

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

categories, including but not limited to primary care providers (PCPs), mental health providers, substance use disorder (SUD) service providers, hospitals and other facilities, and several types of physician specialists as shown in Appendix A. For each MCE, HSAG calculated the percentage of members able to access care within the time or distance requirements defined in the DHHS MCM/DMCM Services Contract and the required reporting template.

- **Network capacity analysis**: New Hampshire requires MCOs to meet network capacity standards for specific types of SUD service providers, and these standards are listed in Appendix A. The scope of this year's work included the following provider types: SUD Master Licensed Alcohol and Drug Counselor (MLADC), opioid treatment provider (OTP), residential SUD treatment program, SUD peer recovery program, and residential serious mental illness (SMI) program. For each of these provider types, DHHS compiled lists of providers identified as licensed and practicing in the State as of December 31, 2024, which were included in the report template provided to the MCOs for their annual reports. For four of the five provider categories, DHHS requires that the MCOs contract with a minimum percentage of the total providers or programs licensed and practicing in the State. For the fifth type, SUD peer recovery programs, MCOs are required to contract with all "willing" providers on the DHHS peer recovery program list. In the absence of contract language defining "willing" in this context, DHHS has accepted the listing of a provider in an MCO's provider file as the best indication that the provider is willing to contract with that MCO. HSAG assessed whether each MCO met these standards by comparing the MCOs' provider data to DHHS' list of licensed and practicing providers.

Appendix B contains further details regarding the methodology.

Key Findings

ISCA findings: HSAG completed an ISCA for each of the MCEs contracted to provide Medicaid services in New Hampshire. HSAG identified no concerns regarding system data processing procedures, enrollment data systems, or provider data systems; each of the MCE's data collection procedures were acceptable. One MCE relied on an external delegated entity for network adequacy indicator reporting, and HSAG identified no issues requiring correction within the last year. Additionally, all MCEs received *High Confidence* ratings for all the network adequacy indicators.

Time and distance analysis: HSAG's time and distance analysis produced results consistent with the results that MCEs reported in their Network.01 data submissions to DHHS. HSAG presents the results across all three MCOs for direct comparison in Appendix D. As required by DHHS, all of the MCEs met either the time or distance standard for most provider categories. **ACNH** met the standards for 95.1 percent of the provider categories, **NHHF** met the standards for 98.4 percent of the provider categories, **WS** met the standards for 96.7 percent of the provider categories, and **NEDD/DQ** met the standards for 100 percent of dental service types.

The MCOs' greatest challenge continues to be contracting with sufficient pediatric specialists to meet access standards, with two of the three MCOs failing to meet standards for allergist/immunologist (**ACNH** and **WS**), ophthalmologist (**ACNH** and **NHHF**), and developmental-behavioral (**ACNH** and

WS). These gaps were acknowledged and addressed in each of the MCO's annual corrective action plan (CAP) reports.

The DO met the standards for all five dental service types across urban, middle, and rural counties.

Network capacity analysis: All three MCOs met the network capacity standard for contracting with willing SUD peer recovery programs from the DHHS list of 18 programs. All MCOs contracted with more than 75.0 percent of the 10 OTPs identified in DHHS' provider list. In addition, two of the three MCOs (ACNH and NHHF) met the standard for contracting with at least 50.0 percent of the 17 listed SUD residential treatment programs, with ACNH contracting with 14 (82.4 percent) and NHHF contracting with 11 (64.7 percent). WS contracted with four (23.5 percent) of those programs. None of the MCOs met standards for residential SMI programs or MLADCs.

Successes

Based on the results of the ISCA combined with the detailed validation of each indicator, the MCEs achieved high scores, meeting most DHHS requirements for network adequacy. All MCEs received *High Confidence* ratings for their data collection procedures, methods, and reporting of the time and distance, network capacity, and access and availability indicators. HSAG provided a report of each MCE's specific results and validation ratings to DHHS and each respective MCE.

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

For the time and distance analysis, all three MCOs met the standards for at least 95.0 percent of the provider categories assessed, and the DO met the standards for 100 percent of the provider categories assessed. HSAG compared each MCE's timely access report filings with their CAPs submitted for SFY 2025 and determined that the MCEs appropriately identified counties where they were unable to meet standards, notified DHHS of the reasons for the unmet standards, and proposed a solution for the deficiency. Most of these deficiencies were reoccurring and traced back several years.

For the network capacity analysis, all three MCOs met the standards for OTPs and SUD peer recovery programs, and two of the three MCOs (ACNH and NHHF) met the standard for residential SUD treatment programs.

Opportunities for Improvement

The MCOs' greatest challenge was contracting with a few specific types of specialists, with two of the three MCOs failing to meet standards for pediatric ophthalmologists (**ACNH** and **NHHF**), pediatric allergy/immunology specialists (**ACNH** and **WS**), and developmental-behavioral pediatricians (**ACNH** and **WS**).

HSAG did not identify any opportunities to improve access for the DO.

All three MCOs should continue to actively recruit additional SUD peer recovery programs from the DHHS list, since some programs that are contracted with one or two MCOs may become willing to add the remaining MCOs to their contracts. In addition, all MCOs should continue to reach out to residential SMI programs and MLADCs from the DHHS lists to meet their standards.

Statewide Recommendations

HSAG recommends that DHHS and the MCEs continue to monitor member access through network adequacy assessments based on the State's expectations.

DHHS should improve its provider lists for the network capacity standards, using MCO feedback as appropriate to provide the best available list of providers for use in calculating the network capacity indicators. DHHS should review its lists of SUD Master Licensed Alcohol and Drug Counselor (MLADC), opioid treatment provider (OTP), residential SUD treatment program, SUD peer recovery program, and residential serious mental illness (SMI) programs to eliminate providers and programs that are no longer active. DHHS should also provide complete street addresses in its lists to allow the MCOs to be sure they are contracting with all providers and provider locations on the lists. DHHS should consider revising the network capacity standards by providing a clear definition of what constitutes a "willing" provider for the SUD peer recovery program standard.

DHHS should consider clarifying the standard for MLADCs and listing only individual NPIs. MLADCs are individually licensed and frequently practice in multiple locations or move between treatment programs. They may be covered under individual or facility NPIs, or both, making matching between the DHHS list and MCO data particularly problematic. Clarifying the list to unique individual MLADCs would improve data comparison across MCOs, and reduce the duplication that occurs when a mixture of individual and group provider NPIs are used.

DHHS should continue to work with HSAG and the MCEs to improve the consistency and quality of reported data. DHHS could provide the MCEs with clear expectations for categorizing providers. DHHS could encourage MCEs to carefully distinguish between individual, organizational, or facility records for provider types that include both individual and organizational or facility providers.

DHHS and the MCEs should continue to review provider categories for which the MCEs did not meet the time and distance or network capacity standards, with the goal of determining whether failure to

meet the standards was due to a lack of providers, a lack of providers willing to contract with Medicaid in general, or providers unwilling to contract with a given MCE.

Time and distance standards set a relatively low bar for MCEs to meet, and even the coverage shown in the analysis can be illusory if members are unable to make appointments as needed. Timely access surveys and grievance and appeals data can provide an additional assessment regarding whether the reported networks are meeting member healthcare access needs. HSAG recommends that DHHS continue to measure appointment availability through secret shopper/revealed caller studies.

2. Validation Results

ACNH

ISCA Findings and Data Validity

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

Information Systems Data Processing Procedures and Personnel

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

- **ACNH** sourced member and provider data from the Core Administration Platform TriZetto Facets v6.1.R2 (Facets) to conduct network adequacy calculation and reporting.
- **ACNH** used Facets as the healthcare benefits administration system to collect and maintain member enrollment and provider data. Facets was upgraded to the latest version in 2024.
- **ACNH** used Symplr Provider (S-Provider), formerly known as Cactus, as the database management system for storing data related to provider credentialing.

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

- **ACNH** had several full-time information system associates working in a programmer role, trained and capable of supporting network adequacy reporting activities. On average, the programmers had approximately 10 to 15 years of experience.

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

Enrollment System

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

- **ACNH** maintained enrollment and eligibility data for Medicaid members within Facets, its healthcare benefits administration system.
- **ACNH** received daily 834 files and processed the files within 24 hours of receipt. **ACNH** also received one monthly reconciliation enrollment file from DHHS at the beginning of each month.

- **ACNH** performed monthly reconciliation between Facets and the 834 enrollment data received from DHHS to ensure completeness and accuracy of enrollment data.
- **ACNH** conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - **ACNH** loaded the enrollment data into Facets, which used a series of business rules to determine if the member already existed in Facets. If it did not find the member, Facets systematically assigned a new unique member ID to the member. If Facets did locate the member, the member retained his or her originally assigned unique member ID.
  - **ACNH** transmitted the enrollment files daily to **ACNH** contracted vendors, which ensured timely receipt of updated enrollment information.
  - The 834 file contained member enrollment and disenrollment information. Once **ACNH** loaded the 834 file into Facets, Facets flagged any data that did not match as expected. If the data did not match, the record defaulted to a daily error report which the Enrollment Department (ED) resolved within 24 hours. An example of this type of error would be a reported end date that occurred prior to the recorded eligibility begin date. This information was accumulated into categories and reported to the ED, which then proactively reviewed, researched, and updated any discrepancies to reconcile the **ACNH** system with the State system.
- **ACNH**'s system captured and maintained both the state-issued Medicaid ID and a system-generated ID. If the Medicaid ID changed for any reason, **ACNH** used the system-generated ID to link enrollment history. **ACNH** maintained a process to match member data elements (e.g., Social Security number [SSN], date of birth [DOB], and gender) to prevent the scenario of a Medicaid member existing under more than one identification number. If **ACNH** discovered duplicate member data, the MCO implemented a process for managing duplicate records to ensure the accuracy of member data by reporting identified duplicates to the State for research. When the State confirmed a duplication, **ACNH** merged records into one single member file through a systematic process.
- **ACNH** identified member demographic updates based on the daily and monthly 834 files received from DHHS. When a member contacted the **ACNH** member service team, the team could make changes to certain demographics and mailing address information. **ACNH** communicated these changes to DHHS weekly via a discrepancy report, which DHHS could use to research and update member enrollment information that would be communicated via a daily 834 file.

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

Provider Data Systems

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

- **ACNH** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- **ACNH** had adequate data collection processes in place to ensure completeness and consistency.

- **ACNH** collected data from providers to support the contracting and credentialing process in standardized formats to the extent feasible and appropriate, utilizing a data feed received directly from the Council for Affordable Quality Healthcare (CAQH). The **ACNH** Enterprise Information Management (EIM) Team used provider data from S-Provider to enrich the data located in Facets. If there was a mismatch between provider title and provider type in Facets, the MCO considered the provider title in S-Provider the source of truth and used the provider title to reconcile any data mismatches in Facets.

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

- **ACNH** maintained provider credentialing and network status data in S-Provider, **ACNH**'s web-based provider database management system. To complete credentialing activities for providers, **ACNH** utilized data from CAQH, such as specialty designation, training, and any provider affiliations. During the credentialing process, **ACNH** also validated data against the following:
  - Office of Inspector General (OIG)
  - System for Award Management (SAM)
  - State Medicaid exclusion lists
  - CMS Preclusion List
  - Provider Opt-Out Affidavits Look-up Tool
  - Social Security Death Master File (DMF)
  - Office of Foreign Assets Control (OFAC)
  - National Plan & Provider Enumeration System (NPPES) Registry
- **ACNH** captured state-required provider types in S-Provider.
- **ACNH**'s procedures for updating and maintaining provider data included the following:
  - **ACNH** maintained and displayed provider contracted status in an online provider directory made available to members. Updates to provider data were based on receipt of the provider application or notification of updates by the provider. Providers were required to update information if it changed and could submit updates through various methods such as email, fax, and postal mail. Typically, providers submitted their updates via email. **ACNH** also conducted an annual demographic review of providers through provider outreach.
  - **ACNH** utilized the daily DHHS Provider Medicaid ID file to monitor and reconcile provider adds and deletes.
  - **ACNH** routinely validated provider self-reported NPI numbers against the NPPES files for any deactivated providers.
  - **ACNH**'s Provider Management Department conducted provider roster reconciliations, including annual provider surveys to confirm and update provider information. **ACNH** also conducted ongoing outreach to review and confirm demographic information.
  - Once **ACNH** fully credentialed a provider, the MCO used provider data from S-Provider to update data in Facets, then used Facets to track providers over time, across multiple locations,

and through changes in participation. This information was also accessible in the Enterprise Data Warehouse (EDW) for network adequacy reporting.

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

Delegated Entity Data and Oversight

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

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

Assessment of Network Adequacy Methods

HSAG assessed **ACNH**'s methodologies for assessing network adequacy and identified the following findings:

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

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

Network Adequacy Indicator Reporting

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

- **ACNH** maintained data control procedures to ensure accuracy and completeness of member and provider data, which **ACNH** extracted from Facets for network adequacy reporting. **ACNH** geocoded the data using QAS, which had built-in data checks that identified data errors for the analyst to review and address as needed.
- **ACNH** assured report quality and accuracy by following a formally documented process. **ACNH**'s supervisory staff reviewed the results for accuracy, completeness, and reasonability prior to submitting the report to the State.
- To ensure continuity of network adequacy indicator production, **ACNH** maintained an internal shared location where programmers could retrieve the reporting requirements and mapping needed to run and archive the reports.

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

Assessment of Data Validity

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

Overall, HSAG determined that **ACNH**'s **data collection procedures** were:

☒ Acceptable
☐ Not acceptable

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

☒ Acceptable
☐ Not acceptable

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

☒ Acceptable
☐ Not acceptable

Analytic Findings

This section describes HSAG's independent assessment of **ACNH**'s compliance with standards for time and distance to providers and network capacity.

Time and Distance Standards

DHHS has set a minimum threshold of 90 percent for compliance with the time and distance standards, which can be satisfied if an MCE meets either the time or distance requirement. **ACNH** met 58 of the 61 time and distance standards that HSAG assessed (95.1 percent), for SFY 2025 as shown in Table 2-1. **ACNH** met all time and distance standards for primary care, hospital services, diagnostic services, other facilities and services, and SUD services. **ACNH** did not meet the standards for three provider types: pediatric allergists/immunologists, development-behavioral pediatricians, and pediatric ophthalmologists. HSAG notes that **ACNH** identified its challenges in providing access to each of those provider types in its quarterly reports and submitted CAPs as required by DHHS.

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

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Primary Care			
Primary Care, Adult	Adults	100%	>99.9%
Primary Care, Pediatric	Children and adolescents	100%	>99.9%
Physician Specialists			
Allergist, Adult	Adults	99.5%	97.5%
Allergist/Immunologist, Pediatric	Children and adolescents	82.0%^	79.5%^
Audiologist, Adult	Adults	100%	100%
Audiologist, Pediatric	Children and adolescents	100%	100%
Cardiologist, Adult	Adults	100%	100%
Cardiologist, Pediatric	Children and adolescents	100%	100%
Dermatologist, Pediatric	Children and adolescents	>99.9%	98.1%
Endocrinologist, Pediatric	Children and adolescents	100%	99.5%
Gastroenterologist, Pediatric	Children and adolescents	100%	99.5%
General Surgeon	All members	100%	100%
Neurologist, Adult	Adults	100%	100%
Neurologist, Pediatric	Children and adolescents	>99.9%	99.4%
Obstetrician/Gynecologist or Other Maternity Provider	Females, ages 13 and older	100%	100%
Oncologist, Adult	Adults	100%	100%
Ophthalmologist, Adult	Adults	97.8%	97.1%
Ophthalmologist, Pediatric	Children and adolescents	77.7%^	72.9%^
Optometrist	All members	100%	>99.9%
Orthopedic Surgeon, Pediatric	Children and adolescents	>99.9%	98.1%
Orthopedist, Adult	Adults	100%	100%
Orthopedist, Pediatric	Children and adolescents	>99.9%	98.1%
Otolaryngologist, Adult	Adults	100%	100%
Otolaryngologist, Pediatric	Children and adolescents	>99.9%	98.1%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Pediatrician, Developmental-Behavioral	Children and adolescents	76.0%^	54.5%^
Plastic Surgeon, Adult	Adults	95.4%	93.7%
Plastic Surgeon, Pediatric	Children and adolescents	>99.9%	99.6%
Podiatry, Adult	Adults	100%	100%
Psychiatrist, Adult	Adults	100%	99.9%
Psychiatrist, Pediatric	Children and adolescents	100%	100%
Psychologist	All members	99.9%	98.8%
Thoracic Surgeon, Adult	Adults	95.9%	93.8%
Urologist, Adult	Adults	100%	100%
Urologist, Pediatric	Children and adolescents	>99.9%	98.7%
Hospital Services			
Hospital—General Acute Care	All members	100%	100%
Hospital—Maternity	Females, ages 13 and older	100%	>99.9%
Hospital—Level 3/4 Neonatal Intensive Care	All members	>99.9%	98.2%
Hospital—Level 1 Major Trauma Treatment	All members	>99.9%	98.2%
Hospital—Diagnostic Cardiac Catheterization	All members	98.5%	97.4%
Hospital—Open-Heart Surgery Services	All members	>99.9%	98.2%
Hospital—Therapeutic Radiation	All members	95.8%	93.8%
Hospital/Short Term Facility for Inpatient Medical Rehabilitation Services	All members	100%	100%
Short Term Care Facility for Involuntary Psychiatric Admissions	All members	95.2%	93.4%
General Inpatient Psychiatric	All members	99.2%	96.5%
Diagnostic Services			

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
CAT (Computed Tomography or CT) Scan Provider	All members	100%	100%
Imaging Provider (Ultrasound & X-Ray) Provider	All members	100%	100%
Magnetic Resonance Imaging Center	All members	100%	100%
Laboratory	All members	100%	100%
Other Facilities and Services			
Pharmacy	All members	100%	99.6%
Durable Medical Equipment (DME)	All members	100%	>99.9%
Adult Medical Daycare	Adults	99.4%	96.0%
Family Planning	All members, ages 13 and older	100%	100%
Licensed Renal Dialysis Provider	All members	99.0%	96.3%
Office Based Physical Therapist/Occupational Therapist/Speech Therapist	All members	100%	100%
Community Mental Health Program	All members	>99.9%	99.6%
Hospice	Adults	99.9%	99.6%
Hospice	All members	99.9%	99.6%
SUD Services			
SUD Master Licensed Alcohol & Drug Counselor	All members	100%	98.8%
Methadone Clinics	All members	95.4%	93.9%
SUD Comprehensive Program	All members	99.9%	99.7%
SUD Outpatient Program	All members	100%	>99.9%

^ The MCO did not meet minimum time and distance standards for this provider category, but addressed the result in its CAP to Restore Provider Network Adequacy.

Network Capacity Analysis

Table 2-2 displays the statewide network capacity analysis results for **ACNH** by provider or program category (i.e., the percentage of providers licensed and practicing within New Hampshire and listed by DHHS that could be identified in the MCO's provider data file). **ACNH** met the standards for OTPs, SUD peer recovery programs, and residential SUD treatment programs.

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

Provider Category	DHHS Standard	Number (%) of Listed Providers or Programs Contracted
MLADC	70% of 184 unique listed NPIs	78 (42.4%)
OTP	75% of 10 listed providers	10 (100%)
SUD peer recovery program	100% of willing listed* programs	11 (100%)
Residential SMI program	100% of 12 listed** programs	8 (66.7%)^
Residential SUD treatment program	50% of 17 listed*** programs	14 (82.4%)

* For this report, DHHS has interpreted a willing program to be those from DHHS' list that has entered a contract with the MCO and therefore appears in its provider data.

** Seven residential SMI programs operated by NFI North were removed from the denominator for network capacity standards, as they are not residential SMI programs.

*** DHHS learned that some of its listed residential SUD treatment programs have elected not to contract with Medicaid, and DHHS' list will be amended for 2026 to reflect this information. HSAG reviewed the impact of removing these providers from this 2025 analysis, and found that while a potential reduction in denominator would have resulted in changes in the MCOs' percentage of provider or programs contracted, it would not have changed the overall met/not met results for any MCO this year. Accordingly, the number of DHHS-listed residential SUD treatment programs was not changed for this report.

^ The MCO did not meet minimum network capacity standards for this provider category.

Although only 42.4 percent of the unique MLADCs on DHHS' list were found in the MCO's provider data, the MCO identified an additional 46 MLADCs not on DHHS' list that were available to its members. With this discrepancy and the finding that the MCO met the time and distance standards for access to MLADCs, DHHS has determined that this indicator will be viewed for informational purposes only this year. DHHS will continue to refine its methodology for creating and sharing reference lists for the provider types covered by network capacity standards for future years.

HSAG identified only eight of the 12 SMI programs listed by DHHS in **ACNH**'s provider data file, which did not meet the standard of 100 percent.

ACNH Validation Ratings

This section presents a summary of the NAV findings indicating HSAG's overall confidence that **ACNH** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table 2-3 summarizes HSAG's validation findings by indicator type.

Table 2-3—Summary of ACNH's Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and Availability	100%	0%	0%	0%
Network Capacity	100%	0%	0%	0%
Time and Distance	100%	0%	0%	0%

Of the network adequacy indicators that HSAG assessed, **ACNH** received *High Confidence* for access and availability, network capacity, and time and distance indicator types.

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths

Strength #1: ACNH established robust processes to keep provider data current and accurate by updating provider data based on the receipt of provider applications or notifications. Providers were able to submit updates through various methods such as email, fax, and postal mail. In addition, **ACNH** conducted ongoing outreach to review and confirm demographic information.

Strength #2: ACNH met the 90 percent time and distance standards for 58 of 61 provider categories (95.1 percent), including all standards for primary care, hospital services, diagnostic services, other facilities and services, and SUD services. As required by DHHS, the MCO requested exceptions in its CAP.

Opportunities for Improvement and Recommendations

Opportunity #1: ACNH did not meet the 90 percent time and distance standards for three pediatric provider categories: allergist/immunologist, pediatric; pediatrician, developmental-behavioral; and ophthalmologist, pediatric.

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

Opportunity #2: ACNH did not meet the relevant network capacity standards for residential SMI programs.

Recommendation: HSAG recommends that **ACNH** maintain current levels of access to care and continue to improve the percentage of DHHS-listed providers with which it contracts to provide all services covered by the network capacity standards, especially for residential SMI programs.

NHHF

ISCA Findings and Data Validity

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

Information Systems Data Processing Procedures and Personnel

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

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

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

- **NHHF** had two programmers with an average of three years of experience who were trained to complete network adequacy reporting, along with one backup programmer. Additionally, **NHHF** reported that a further backup programmer was to be trained in upcoming months.

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

Enrollment System

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

- **NHHF** received a daily and monthly 834 file which contained enrollment information received from the State secure file transfer protocol (SFTP).
- When DHHS provided the daily 834 file to **NHHF**, the MCO processed the enrollment data in UMV, which included updates for new members, terminations, and changes to existing members. If the 834 file contained any discrepancies that conflicted with the current data in UMV, **NHHF**'s analyst reviewed the information for accuracy.

- **NHHF** conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - Each month, **NHHF** generated a mid-compare file and submitted an all-active membership list to the State for review. The MCO investigated any discrepancies the State identified through a complete review of the 834 file history and returned any findings to **NHHF**. The MCO manually corrected any errors found in its system and communicated all other errors back to the State for resolution. This process continued until all discrepancies were resolved.
- **NHHF**'s system generated a member ID number based on the Medicaid ID on the 834 file. Additionally, **NHHF** generated reports to assist in identifying any duplicate members. For confirmed duplicates, **NHHF** merged the records in the system, retained both Medicaid IDs, and stored the full membership history within its information systems.
- If DHHS assigned a new Medicaid number to an existing member, **NHHF** developed logic within the eligibility load program to find duplicate SSNs. If the program found duplicates, the member record triggered an error for manual review.
- **NHHF** identified a member's residence through the 834 file, which was considered the source of truth. In situations of homelessness, the State typically assigned a DHHS district office as the address location.

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

Provider Data Systems

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

- **NHHF** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- **NHHF** had adequate data collection processes in place to ensure completeness and consistency.
- **NHHF** required providers to make updates as they occurred. Every three months, Veda, **NHHF**'s corporate vendor for provider data cleansing, audited provider data, and **NHHF** updated its systems accordingly to ensure accuracy.

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

- **NHHF** utilized Amisys and Portico to gather provider data for its medical providers, reviewing provider enrollment documents for accuracy against NPPES, the State file, and CAQH. Additionally, **NHHF** used CenProv, a Centene-specific database, to track all provider credentialing information; the MCO then processed the documents submitted through CenProv for enrollment and credentialing through Portico and Amisys to facilitate claims payment.
- **NHHF** completed credentialing upon initial enrollment and reverified credentialing every three years as required by the State.

- **NHHF**'s procedures for updating and maintaining provider data included the following:
  - **NHHF** stored provider demographic information in Portico, which had the capability to track providers over time, across multiple office locations, and through changes in participation in the **NHHF** network.
  - **NHHF**'s Provider Data Integrity (PDI) Tool reviewed all systems for discrepancies and allowed the Provider Data Team to make necessary updates within the tool or submit tickets through CenProv for provider updates.

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

Delegated Entity Data and Oversight

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

- **NHHF** subcontracted vision services to Envolve Vision and pharmacy services to Centene Pharmacy Services.
- **NHHF** maintained oversight of its delegated entities by:
  - Contractually requiring delegated entities to meet all State and federal eligibility criteria, reporting requirements, and any other applicable statutory rules and/or regulations related to the State contract.
  - Requiring monthly reporting that included timeliness data and delegated entities presenting metrics at Joint Operating Committee meetings.
  - Providing the specifications for network adequacy so that vendors could calculate results based on the DHHS MCM contract's time and distance standards. Vendors then submitted results to **NHHF** to review and verify for completion of required data elements.

Assessment of Network Adequacy Methods

HSAG evaluated **NHHF**'s methodologies for assessing network adequacy and identified the following findings:

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

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

Network Adequacy Indicator Reporting

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

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

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

Assessment of Data Validity

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

Overall, HSAG determined that **NHHF**'s **data collection procedures** were:

☒ Acceptable
☐ Not acceptable

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

☒ Acceptable
☐ Not acceptable

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

☒ Acceptable
☐ Not acceptable

Analytic Findings

This section describes HSAG's independent assessment of **NHHF**'s compliance with standards for time and distance to providers and network capacity analysis.

Time and Distance Standards

DHHS has set a minimum threshold of 90 percent for compliance with the time and distance standards, which can be satisfied if an MCE meets either the time or distance requirement. **NHHF** met 60 of the 61 time and distance standards that HSAG assessed (98.4 percent), as shown in Table 2-4. **NHHF** met the standards for all primary care, hospital services, diagnostic services, other facilities and services, and SUD services. **NHHF** did not identify a pediatric ophthalmologist in its network, but the MCO did request exceptions and provided corrective action. HSAG notes that **NHHF** identified its challenges in providing access to this provider type, requesting an exception for this provider type in all counties, citing a lack of qualified providers willing to contract, and pointing out that all members requiring these services were seen by fully licensed ophthalmologists. **NHHF** has submitted annual exception requests and CAPs for this provider type since 2017.

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

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Primary Care			
Primary Care, Adult	Adults	100%	99.9%
Primary Care, Pediatric	Children and adolescents	100%	>99.9%
Physician Specialists			
Allergist, Adult	Adults	99.9%	97.7%
Allergist/Immunologist, Pediatric	Children and adolescents	98.8%	93.5%
Audiologist, Adult	Adults	100%	100%
Audiologist, Pediatric	Children and adolescents	100%	100%
Cardiologist, Adult	Adults	100%	100%
Cardiologist, Pediatric	Children and adolescents	100%	100%
Dermatologist, Pediatric	Children and adolescents	>99.9%	97.2%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Endocrinologist, Pediatric	Children and adolescents	>99.9%	99.3%
Gastroenterologist, Pediatric	Children and adolescents	>99.9%	97.2%
General Surgeon	All members	100%	100%
Neurologist, Adult	Adults	100%	100%
Neurologist, Pediatric	Children and adolescents	100%	100%
Obstetrician/Gynecologist or Other Maternity Provider	Females, ages 13 and older	100%	100%
Oncologist, Adult	Adults	100%	100%
Ophthalmologist, Adult	Adults	99.9%	99.2%
Ophthalmologist, Pediatric	Children and adolescents	0.0%^	0.0%^
Optometrist	All members	100%	100%
Orthopedic Surgeon, Pediatric	Children and adolescents	100%	98.1%
Orthopedist, Adult	Adults	100%	100%
Orthopedist, Pediatric	Children and adolescents	100%	100%
Otolaryngologist, Adult	Adults	100.0%	100%
Otolaryngologist, Pediatric	Children and adolescents	98.8%	92.3%
Pediatrician, Developmental-Behavioral	Children and adolescents	91.4%	78.0%
Plastic Surgeon, Adult	Adults	99.3%	98.8%
Plastic Surgeon, Pediatric	Children and adolescents	100%	100%
Podiatry, Adult	Adults	100%	100%
Psychiatrist, Adult	Adults	100%	100%
Psychiatrist, Pediatric	Children and adolescents	100%	99.4%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Psychologist	All members	100.0%	>99.9%
Thoracic Surgeon, Adult	Adults	94.5%	93.3%
Urologist, Adult	Adults	100%	>99.9%
Urologist, Pediatric	Children and adolescents	>99.9%	97.2%
Hospital Services			
Hospital—General Acute Care	All members	100%	100%
Hospital—Maternity	Females, ages 13 and older	99.9%	99.2%
Hospital—Level 3/4 Neonatal Intensive Care	All members	>99.9%	97.2%
Hospital—Level 1 Major Trauma Treatment	All members	100%	100%
Hospital—Diagnostic Cardiac Catheterization	All members	98.0%	95.0%
Hospital—Open-Heart Surgery Services	All members	>99.9%	97.2%
Hospital—Therapeutic Radiation	All members	93.1%	91.6%
Hospital/Short Term Facility for Inpatient Medical Rehabilitation Services	All members	100%	99.6%
Short Term Care Facility for Involuntary Psychiatric Admissions	All members	93.1%	91.4%
General Inpatient Psychiatric	All members	98.8%	96.3%
Diagnostic Services			
CAT Scan Provider	All members	100%	100%
Imaging Provider (Ultrasound & X-Ray) Provider	All members	100%	100%
Magnetic Resonance Imaging Center	All members	100%	100%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Laboratory	All members	100%	100%
Other Facilities and Services			
Pharmacy	All members	100%	99.5%
DME	All members	100%	>99.9%
Adult Medical Daycare	Adults	98.7%	93.6%
Family Planning	All members, ages 13 and older	100%	100%
Licensed Renal Dialysis Provider	All members	100%	>99.9%
Office Based Physical Therapist/Occupational Therapist/Speech Therapist	All members	100%	100%
Community Mental Health Program	All members	100%	99.7%
Hospice	Adults	99.9%	99.2%
Hospice	All members	99.9%	99.3%
SUD Services			
SUD Master Licensed Alcohol & Drug Counselor	All members	99.3%	91.7%
Methadone Clinics	All members	93.8%	92.2%
SUD Comprehensive Program	All members	99.9%	99.5%
SUD Outpatient Program	All members	100%	99.9%

^ The MCO did not meet minimum time and distance standards for this provider category, but addressed the result in its CAP to Restore Provider Network Adequacy.

Network Capacity Analysis

Table 2-5 displays the statewide network capacity analysis results for **NHHF** by provider or program category (i.e., the percentage of providers licensed and practicing within New Hampshire and listed by DHHS that could be identified in the MCO's provider data file). **NHHF** met the standards for OTPs, SUD peer recovery programs, and residential SUD treatment programs.

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

Provider Category	DHHS Standard	Number (%) of Listed Providers or Programs Contracted
MLADC	70% of 184 unique listed NPIs	36 (19.6%)
OTP	75% of 10 listed providers	9 (90.0%)
SUD peer recovery program	100% of willing listed* programs	12 (100%)
Residential SMI program	100% of 12 listed** programs	8 (66.7%)^
Residential SUD treatment program	50% of 17 listed*** programs	11 (64.7%)

* For this report, DHHS has interpreted a willing program to be one from DHHS' list that has entered a contract with the MCO and therefore appears in its provider data.

** Seven residential SMI programs operated by NFI North were removed from the denominator for network capacity standards, as they are not residential SMI programs.

*** DHHS learned that some of its listed residential SUD treatment programs have elected not to contract with Medicaid, and DHHS' list will be amended for 2026 to reflect this information. HSAG reviewed the impact of removing these providers from this 2025 analysis, and found that while a potential reduction in denominator would have resulted in changes in the MCOs' percentage of provider or programs contracted, it would not have changed the overall met/not met results for any MCO this year. Accordingly, the number of DHHS-listed residential SUD treatment programs was not changed for this report.

^ The MCO did not meet minimum network capacity standards for this provider category.

Although only 19.6 percent of the unique MLADCs on DHHS' list were found in the MCO's provider data, **NHHF** identified an additional 15 MLADCs not on DHHS' list that were available to its members. DHHS has determined that this indicator will be reviewed for informational purposes only this year, as it continues to improve its ability to specify a denominator for this indicator. This result should also be viewed in conjunction with the MCO meeting the time and distance standards for access to MLADCs.

HSAG identified only eight of the 12 SMI programs listed by DHHS in **NHHF**'s provider data file, which did not meet the standard of 100 percent.

NHHF Validation Ratings

This section presents a summary of the NAV findings indicating HSAG's overall confidence that **NHHF** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table 2-6 summarizes HSAG's validation results by indicator type.

Table 2-6—Summary of NHHF's Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and Availability	100%	0%	0%	0%
Network Capacity	100%	0%	0%	0%
Time and Distance	100%	0%	0%	0%

Of the network adequacy indicators that HSAG assessed, **NHHF** received *High Confidence* for access and availability, network capacity, and time and distance indicator types.

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths

Strength #1: NHHF established an effective process to prevent potential member duplication when a member was assigned a new Medicaid ID number. **NHHF** built logic through an eligibility program to identify and prevent duplicate SSNs. This ensured that the member retained the same Medicaid ID, which maintained continuity in coverage and minimized errors.

Strength #2: NHHF met the 90 percent time and distance standards for 60 of 61 provider categories (98.4 percent), including all standards for primary care, hospital services, diagnostic services, other facilities and services, and SUD services. As required by DHHS, the MCO requested exceptions in its CAP.

Opportunities for Improvement and Recommendations

Opportunity #1: NHHF did not meet the 90 percent time and distance standard for one provider category: ophthalmologist, pediatric.

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

Opportunity #2: NHHF did not meet the relevant network capacity standards for residential SMI programs.

Recommendation: HSAG recommends that **NHHF** maintain current levels of access to care and continue to improve the percentage of DHHS-listed providers with which it contracts to provide all services covered by the network capacity standards, especially for residential SMI programs.

WS

ISCA Findings and Data Validity

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

Information Systems Data Processing Procedures and Personnel

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

- **WS** used Facets as the database management system to maintain comprehensive member and provider data.
- **WS** used Onyx as the database management systems to store and manage provider data.
- **WS** used the S-Provider database management system to store the final verification of all information in each provider's credentialing application, as well as the final credentialing completion date.
- **WS** used EDW as a centralized data repository to produce member- and provider-specific data files used to conduct network adequacy calculation and reporting.

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

- **WS** had 13 programmers trained and capable of supporting network adequacy reporting activities. On average, the programmers had 15 years of experience in the field.

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

Enrollment System

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

- **WS** received daily electronic 834 files from DHHS and processed them within 24 hours of receipt.
- **WS** performed monthly oversight and reconciliation of Facets and DHHS enrollment data to ensure data completeness and accuracy, which included the following activities:
  - The MCO received and processed the monthly 834 file within three days of receipt via SFTP and loaded the file directly into **WS**'s member enrollment database management system, Facets.
- **WS** ensured that required data fields were present before loading any membership data into Facets, using keywords to analyze for transactional consistency, tracking (e.g., enrollments,

updates/changes, deletions), and errors. Once **WS** completed its analysis, the MCO processed the file into Facets. If any data did not match, **WS** generated a daily error report which the ED resolved within 24 hours. **WS** enrollment representatives used information reflected on the New Hampshire Eligibility Verification Portal to verify eligibility data. If the portal did not provide adequate information, **WS** escalated the issue to a department supervisor and/or manager who worked directly with DHHS to achieve resolution.

  - **WS** assigned each member a unique member ID number with a prefix of "NH," which was linked to the member's unique, DHHS-assigned Medicaid ID. If the member disenrolled and then subsequently reenrolled, **WS** assigned the member the same unique member ID number to ensure continuity.

- **WS** used various demographic data combinations to match member data elements and assist with the identification of members (e.g., name, DOB, address, and gender).
- **WS** assigned newborn members temporary ID numbers which it used until receiving notice of the permanent record from DHHS. Upon receipt of successful enrollment notification from DHHS, **WS** merged the temporary member ID number with the permanent number to eliminate duplicate records.
- If **WS** assigned two active Medicaid ID numbers to a member, the ED researched the two numbers and consulted with DHHS to determine the correct Medicaid ID, merged the two records to the active Medicaid ID number, and eliminated the duplicate member ID. **WS** linked all previous enrollment, claim, and encounter data to the active member record.
- **WS**'s member enrollment database management system, Facets, maintained an unlimited number of lines of eligibility history for each member, which could be used to track and maintain Medicaid eligibility, including retroactive eligibility. Each line of eligibility history also had a corresponding Medicaid Management Information System (MMIS) transaction, which enrollment representatives could review to determine prospective or retroactive changes in eligibility.
- **WS** staff documented member demographic changes in the call center notes and tracked the changes in Facets within the audit history record. **WS** staff verified the changes by matching member demographic information to data in the MMIS look-up tool. If the look-up tool did not provide adequate information, the MCO escalated the issue to a department supervisor and/or manager who would work directly with a DHHS contact to achieve resolution.

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

Provider Data Systems

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

- **WS** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- **WS** had adequate data collection processes in place to ensure completeness and consistency.

- **WS** collected data from providers to support the contracting and credentialing process in standardized formats to the extent feasible and appropriate.

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

- **WS** maintained provider credentialing data in Onyx and S-Provider.
- **WS** used Facets to maintain network status data and capture state-required provider types.
- **WS**'s procedures for updating and maintaining provider data included the following:
  - The MCO entered provider additions into Onyx and sent these additions to Verisys for credentialing verification.
- **WS** streamlined its credentialing process through a partnership with the National Committee for Quality Assurance (NCQA) accredited Credentialing Verification Organization (CVO), Verisys, to provide primary source verification (PSV). Verisys used the CVOne system to document required PSV of provider information for credentialing. The CVO managed the application gathering and PSV processes, ensuring accuracy by verifying information with NCQA-approved sources and prompting providers for missing details. The CVO pulled information from CAQH and verified provider data such as specialties, license, etc.
- **WS** considered a credentialing application to be clean and complete once Verisys collected the required data elements that accompanied or were included in the provider's CAQH application.
- **WS** documented all PSV stored in CVOne within its own credentialing system, S-Provider. **WS** also used S-Provider as its source system to document the final verification of all information within each provider's credentialing application, as well as the final credentialing completion date.
  - After provider credentialing, **WS** completed the payment and group validation to prepare the record for batching into Facets from Onyx. This batch was scheduled to run every weekday in the evening. **WS** inserted any provider that failed in the batch and that did not migrate to Facets into an error table. The MCO reviewed the table daily on the following morning and rectified any errors in order for that day's evening batch to pick up the corrections and update in Facets.
  - **WS**'s Provider ED reviewed any provider-related correspondence, including provider-submitted changes and the daily NH Medicaid ID report that DHHS provided, to determine whether a provider was being added or terminated from the plan.
  - **WS** managed provider terminations in Onyx. When **WS** received email notification of a provider's termination, the MCO updated the provider record and migrated the change to Facets using the daily Facets batch process.
  - **WS** verified provider information during credentialing and recredentialing which occurred every two to three years. Additionally, providers were contractually required to report all changes such as name, NPI, Taxpayer Identification Number (TIN), locations, and phone numbers within 30 days in advance of the change.
  - **WS** obtained the Provider Medicaid ID from the provider and confirmed the accuracy on the daily New Hampshire Medicaid ID report. **WS** validated the Provider Medicaid ID monthly.
  - The **WS** Provider Relations Department also met with providers quarterly to review information for accuracy.

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

Delegated Entity Data and Oversight

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

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

Assessment of Network Adequacy Methods

HSAG evaluated WS's methodologies for assessing network adequacy and identified the following findings:

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

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

Network Adequacy Indicator Reporting

HSAG assessed WS's network adequacy indicator reporting processes and identified the following findings:

- WS conducted data reasonability checks by comparing all results to the previous years' results.
- WS maintained network adequacy indicator reports by saving all reports with a two-digit year and two-digit month (YYMM) naming convention format, with the date representing the period for which the report was produced. WS had internal backups to ensure that it maintained all materials associated with the network adequacy reports.
- To ensure continuity of network adequacy indicator production, WS reviewed all results against the previous years' results and with the contracting team.

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

Assessment of Data Validity

HSAG evaluated and assessed the data methods that WS used to collect and store data for each network adequacy indicator in the scope of NAV. HSAG used indicator-specific worksheets to generate a

validation rating that reflects HSAG's overall confidence that **WS** used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Overall, HSAG determined that **WS**'s **data collection procedures** were:

☒ Acceptable
☐ Not acceptable

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

☒ Acceptable
☐ Not acceptable

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

☒ Acceptable
☐ Not acceptable

Analytic Findings

This section describes HSAG's independent assessment of **WS**'s compliance with standards for time and distance to providers and network capacity analysis.

Time and Distance Standards

DHHS has set a minimum threshold of 90 percent for compliance with the time and distance standards, which can be satisfied if the MCE meets either the time or distance requirement. **WS** met 59 of the 61 time and distance standards that HSAG assessed (96.7 percent), as shown in Table 2-7. **WS** met all standards for primary care, hospital services, diagnostic services, other facilities and services, and SUD services. However, some **WS** members did not have access within the standards to pediatric allergists/immunologists or development-behavioral pediatricians in its network. HSAG notes that **WS** identified its challenges in providing access to each of these provider types in its quarterly reports and submitted CAPs as required by DHHS.

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

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Primary Care			
Primary Care, Adult	Adults	100%	>99.9%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Primary Care, Pediatric	Children and adolescents	100%	>99.9%
Physician Specialists			
Allergist, Adult	Adults	95.6%	94.0%
Allergist/Immunologist, Pediatric	Children and adolescents	78.2%^	72.1%^
Audiologist, Adult	Adults	100%	100%
Audiologist, Pediatric	Children and adolescents	100%	100%
Cardiologist, Adult	Adults	100%	100%
Cardiologist, Pediatric	Children and adolescents	100%	100%
Dermatologist, Pediatric	Children and adolescents	>99.9%	98.1%
Endocrinologist, Pediatric	Children and adolescents	>99.9%	99.4%
Gastroenterologist, Pediatric	Children and adolescents	>99.9%	98.3%
General Surgeon	All members	100%	100%
Neurologist, Adult	Adults	100%	100%
Neurologist, Pediatric	Children and adolescents	>99.9%	99.4%
Obstetrician/Gynecologist or Other Maternity Provider	Females, ages 13 and older	100%	100%
Oncologist, Adult	Adults	100.0%	>99.9%
Ophthalmologist, Adult	Adults	99.9%	99.6%
Ophthalmologist, Pediatric	Children and adolescents	100%	100%
Optometrist	All members	98.5%	97.3%
Orthopedic Surgeon, Pediatric	Children and adolescents	100%	100%
Orthopedist, Adult	Adults	100%	100%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Orthopedist, Pediatric	Children and adolescents	100%	100%
Otolaryngologist, Adult	Adults	100%	100%
Otolaryngologist, Pediatric	Children and adolescents	100%	100%
Pediatrician, Developmental-Behavioral	Children and adolescents	82.7%^	55.1%^
Plastic Surgeon, Adult	Adults	95.6%	93.6%
Plastic Surgeon, Pediatric	Children and adolescents	>99.9%	99.6%
Podiatry, Adult	Adults	100%	100%
Psychiatrist, Adult	Adults	97.0%	82.4%
Psychiatrist, Pediatric	Children and adolescents	100%	100%
Psychologist	All members	99.9%	97.5%
Thoracic Surgeon, Adult	Adults	96.1%	95.4%
Urologist, Adult	Adults	100%	100%
Urologist, Pediatric	Children and adolescents	>99.9%	98.1%
Hospital Services			
Hospital—General Acute Care	All members	100%	>99.9%
Hospital—Maternity	Females, ages 13 and older	>99.9%	99.7%
Hospital—Level 3/4 Neonatal Intensive Care	All members	>99.9%	98.1%
Hospital—Level 1 Major Trauma Treatment	All members	>99.9%	98.1%
Hospital—Diagnostic Cardiac Catheterization	All members	>99.9%	99.6%
Hospital—Open-Heart Surgery Services	All members	>99.9%	98.1%

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	**Member Population**	**Time**	**Distance**
Hospital—Therapeutic Radiation	All members	100%	98.3%
Hospital/Short Term Facility for Inpatient Medical Rehabilitation Services	All members	100%	100%
Short Term Care Facility for Involuntary Psychiatric Admissions	All members	93.5%	90.6%
General Inpatient Psychiatric	All members	100%	99.2%
Diagnostic Services			
CAT Scan Provider	All members	100%	100%
Imaging Provider (Ultrasound & X-Ray) Provider	All members	100%	100%
Magnetic Resonance Imaging Center	All members	100%	100%
Laboratory	All members	100%	100%
Other Facilities and Services			
Pharmacy	All members	100%	99.8%
DME	All members	100%	100%
Adult Medical Daycare	Adults	99.3%	95.1%
Family Planning	All members, ages 13 and older	98.2%	96.1%
Licensed Renal Dialysis Provider	All members	100%	>99.9%
Office Based Physical Therapist/Occupational Therapist/Speech Therapist	All members	100%	100%
Community Mental Health Program	All members	100%	99.5%
Hospice	Adults	99.9%	99.6%
Hospice	All members	>99.9%	99.6%
SUD Services			

		Percent of Members With Access Within Time or Distance Standards	
Provider Category	Member Population	Time	Distance
SUD Master Licensed Alcohol & Drug Counselor	All members	99.9%	89.5%
Methadone Clinics	All members	95.5%	94.4%
SUD Comprehensive Program	All members	95.6%	94.4%
SUD Outpatient Program	All members	98.3%	97.5%

^ The MCO did not meet minimum time and distance standards for this provider category, but addressed the result in its CAP to Restore Provider Network Adequacy.

Network Capacity Analysis

Table 2-8 displays the statewide network capacity analysis results for **WS** (i.e., the percentage of providers licensed and practicing within New Hampshire and listed by DHHS that could be identified in the MCO's provider data file). **WS** met the standards for OTPs and SUD peer recovery programs.

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

Provider Category	DHHS Standard	Number (%) of Listed Providers or Programs Contracted
MLADC	70% of 184 unique listed NPIs	14 (7.6%)
OTP	75% of 10 listed providers	10 (100.0%)
SUD peer recovery programs	100% of willing listed* programs	9 (100%)
Residential programs for SMI	100% of 12 listed** programs	8 (66.7%)^
Residential SUD treatment program	50% of 17 listed*** programs	4 (23.5%)^

* For this report, DHHS has interpreted a willing program to be one from DHHS' list that has entered a contract with the MCO and therefore appears in its provider data.

** Seven residential SMI programs operated by NFI North were removed from the denominator for network capacity standards, as they are not residential SMI programs.

*** DHHS learned that some of its listed residential SUD treatment programs have elected not to contract with Medicaid, and DHHS' list will be amended for 2026 to reflect this information. HSAG reviewed the impact of removing these providers from this 2025 analysis, and found that while a potential reduction in denominator would have resulted in changes in the MCOs' percentage of provider or programs contracted, it would not have changed the overall met/not met results for any MCO this year. Accordingly, the number of DHHS-listed residential SUD treatment programs was not changed for this report.

^ The MCO did not meet minimum network capacity standards for this provider category.

Although only 7.6 percent of the MLADCs on DHHS' list were found in the MCO's provider data, **WS** identified an additional 25 MLADCs not on DHHS' list that were available to its members. DHHS has determined that this indicator will be reviewed for informational purposes only this year, as it continues

to improve its ability to specify a denominator for this indicator. This result should also be viewed in conjunction with the MCO meeting the time and distance standards for access to MLADCs.

HSAG identified only eight of the 12 SMI programs listed by DHHS and four of the 17 Residential SUD treatment programs listed by DHHS in **WS'**s provider data file, which did not meet either the standard of 100 percent for the former, and 50 percent for the latter.

WS Validation Ratings

This section presents a summary of the NAV findings indicating HSAG's overall confidence that **WS** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table 2-9 summarizes HSAG's validation findings by indicator type.

Table 2-9—Summary of WS's Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and Availability	100%	0%	0%	0%
Network Capacity	100%	0%	0%	0%
Time and Distance	100%	0%	0%	0%

Of the network adequacy indicators that HSAG assessed, **WS** received *High Confidence* for access and availability, network capacity, and time and distance indicator types.

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths

Strength #1: WS established a robust process to keep provider data current and accurate through its quarterly Provider Relations Department meetings with providers to review information for accuracy, its credentialing and recredentialing process which occurred every two to three years, and the contract requirement for providers to report all changes within 30 days in advance of the change.

Strength #2: WS met the 90 percent time and distance standards for 59 of 61 provider categories (96.7 percent), including all standards for primary care, hospital services, diagnostic services, other facilities and services, and SUD services. As required by DHHS, the MCO requested exceptions in its CAP.

Opportunities for Improvement and Recommendations

Opportunity #1: WS did not meet the 90 percent time and distance standards for two pediatric provider categories: allergist/immunologist, pediatric and pediatrician, developmental-behavioral.

Recommendation: HSAG recommends that **WS** maintain the current level of access to care and continue to address network gaps for pediatric allergists/immunologists and developmental-behavioral pediatricians.

Opportunity #2: WS did not meet the relevant network capacity standards for two provider types:, residential SMI programs, and residential SUD treatment programs.

Recommendation: HSAG recommends that **WS** maintain current levels of access to care and continue to improve the percentage of DHHS-listed providers with which it contracts to provide all services covered by the network capacity standards, especially for residential SMI programs, and residential SUD treatment programs.

NEDD/DQ

ISCA Findings and Data Validity

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

Information Systems Data Processing Procedures and Personnel

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

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

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

- **NEDD/DQ** had eight programmers dedicated to networking adequacy reporting. These programmers had an average of 10 years of experience.

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

Enrollment System

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

- **NEDD/DQ** received enrollment and eligibility data for Medicaid members daily and monthly from DHHS, which included member effective and termination dates, via an SFTP site.
- **NEDD/DQ** processed enrollment files daily through its proprietary electronic, three-stage enrollment process.
  - Stage 1— a pre-process step to validate data (e.g., identifying invalid characters and ensuring appropriate formatting).

  - Stage 2— a second step to identify any data already on file and pending transactions as needed to apply applicable changes.
  - Stage 3—a third step which included reasonability checks and error reporting checks.
- **NEDD/DQ** updated any changes within 24 hours of receipt in Windward.
- **NEDD/DQ** received full files once per month and daily change files in the 834 file format from DHHS, processed enrollment files through Windward, and updated enrollment changes in near real-time.
- **NEDD/DQ** conducted ongoing reconciliation and oversight of enrollment data, which included the following activities:
  - **NEDD/DQ** used the first full 834 file of the month to audit and verify coverage for members enrolled in Windward.
  - **NEDD/DQ** employed an Automated Member Reconciliation (AMR) system to reconcile monthly 834 files with the existing data in Windward. The AMR system automatically detected discrepancies, applying a "Terminated by Absence" rule to set termination dates to the last day of the previous month. This process guaranteed accuracy and consistency in member data.
  - **NEDD/DQ** performed data integrity and accuracy testing between source systems and the EDW using QuerySurge, a tool designed to identify any variances that the DO needed to address to ensure data completeness.
- The **NEDD/DQ** system captured and maintained both the state-issued Medicaid ID and system-generated universal ID (UID). The UID remained with a member if the member was terminated and later reinstated. If the member moved to another state, the UID would follow the member to his or her new coverage.
- **NEDD/DQ** identified member demographic updates based on the 834 file that DHHS provided and used the 834 file to determine residence addresses. In the case of homelessness or a P.O. Box-only address, the DO used the post office county table to assign counties. If a member reached out to update demographic information, Customer Service referred the member back to DHHS to make the update.

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

Provider Data Systems

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

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

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

- **NEDD/DQ** maintained provider credentialing data, such as type, specialty, and taxonomy, in S-Provider.
- **NEDD/DQ** maintained provider network status data in Windward.
- **NEDD/DQ** extracted data from S-Provider and Windward for timely credentialing reporting. The credentialing process start date was the date that **NEDD/DQ** received the clean, complete application in S-Provider. The end date was the date that **NEDD/DQ** sent the provider notification of enrollment via the welcome letter. **NEDD/DQ** tracked the start and end dates and filtered them by general providers and specialists.
- **NEDD/DQ**'s procedures for updating and maintaining provider data included the following:
  - **NEDD/DQ** received requests to add and/or change provider data through multiple channels such as from provider offices directly or through internal credentialing and provider engagement personnel authorized to submit changes. **NEDD/DQ** entered the provider information received from the internal credentialing team directly into Windward with data the provider supplied through **NEDD/DQ**'s prescribed credentialing process. Internal staff validated the information through PSV. Authorized internal staff manually updated and maintained existing provider records in Windward after validating the data. Staff updated the provider data information field in Windward first and then manually updated the information in S-Provider after validating the data.
  - **NEDD/DQ** also conducted a weekly reconciliation process against the daily Master Provider file from DHHS to verify provider IDs and ensure the provider was active in the State. Actions to address any identified errors included, but were not limited to, contacting the provider to validate correct data, updating Windward to reflect data on the Master Provider file, and removing the provider from the network.
  - When provider data changed regarding new addresses or when a provider added an office location, the provider received a PDF fillable form via email or fax, which **NEDD/DQ** required the provider to complete. Once the provider completed the update form, ServiceNow sent a ticket to the provider operations team, and **NEDD/DQ** updated the information directly in Windward.
  - **NEDD/DQ** had control processes built into Windward that prevented duplicate provider locations, such as using the TIN search bar which allowed **NEDD/DQ** staff to either choose an existing TIN to avoid duplicates or create a new location that **NEDD/DQ** attached to the provider's list of locations when updating provider data information.
  - **NEDD/DQ** also verified service locations and provider phone numbers through a quarterly validation process.

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

Delegated Entity Data and Oversight

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

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

Assessment of Network Adequacy Methods

HSAG evaluated **NEDD/DQ**'s methodologies for assessing network adequacy and identified the following findings:

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

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

Network Adequacy Indicator Reporting

HSAG assessed **NEDD/DQ**'s network adequacy indicator reporting processes and identified the following findings:

- **NEDD/DQ** maintained data control procedures to ensure accuracy and completeness of data merges from Windward by utilizing QuerySurge to identify variances requiring action. **NEDD/DQ** also reconciled against its general ledger to ensure data had been captured accurately. Additionally, **NEDD/DQ** performed data mapping in QAS for both the Enterprise Reporting Multi-Use Directory Report (provider file) and Active Membership Detail Report (membership file).
- **NEDD/DQ** conducted data reasonability checks on the provider file and membership file by completing month-over-month comparisons against prior member and provider data files, and likewise compared the output against prior reports.
- **NEDD/DQ** maintained network adequacy indicator reports by exporting the reports and storing iterations in a secure folder, according to run date. Multiple **NEDD/DQ** teams validated network adequacy reports. To ensure continuity of network adequacy indicator production, **NEDD/DQ** maintained copies of previous reports at a designated location.

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

Assessment of Data Validity

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

Overall, HSAG determined that **NEDD/DQ**'s **data collection procedures** were:

☒ Acceptable
☐ Not acceptable

Overall, HSAG determined that **NEDD/DQ**'s **network adequacy methods** were:

☒ Acceptable
☐ Not acceptable

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

☒ Acceptable
☐ Not acceptable

Analytic Findings

This section describes HSAG's independent assessment of **NEDD/DQ's** compliance with standards for time and distance to providers.

Time and Distance Standards

DHHS set a minimum threshold of 90 percent for compliance with the time and distance standards, which can be satisfied if the DO meets either the time or distance requirement. **NEDD/DQ** met the time or distance standards for 100 percent of the dental service types assessed for SFY 2025.

Table 2-10 displays the percentage of **NEDD/DQ's** members statewide who had the access to care required by contract standards for all applicable provider categories.

Table 2-10—Percentage of Members With Required Access to Care by Provider Category for NEDD/DQ

	Percent of Members With Access Within Time or Distance Standards					
	Urban Counties		Middle Counties		Rural Counties	
Type of Service	Time	Distance	Time	Distance	Time	Distance
Dental Restorative Services	96.7%	92.4%	100.0%	97.1%	100.0%	100.0%
Dental Oral and Maxillofacial Surgery	99.2%	95.7%	99.9%	87.5%	99.6%	28.8%
Dental Adjunctive General Services	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%
Dental Diagnostic Services	96.7%	92.6%	100.0%	97.1%	100.0%	100.0%
Dental Preventive Services	96.7%	92.4%	100.0%	97.1%	100.0%	100.0%

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

NEDD/DQ met 15 of the 15 time and distance standards that HSAG assessed (100 percent). **NEDD/DQ** met the standards across urban, middle, and rural counties for all five dental service types.

NEDD/DQ Validation Ratings

This section presents a summary of the NAV findings indicating HSAG's overall confidence that **NEDD/DQ** used acceptable methodology for all phases of design, data collection, analysis, and interpretation of each network adequacy indicator. Table 2-11 summarizes HSAG's validation results by indicator type.

Table 2-11—Summary of NEDD/DQ's Validation Findings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Access and Availability	100%	0%	0%	0%
Time and Distance	100%	0%	0%	0%

Of the network adequacy indicators that HSAG assessed, **NEDD/DQ** received *High Confidence* for access and availability and time and distance indicator types.

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths

Strength #1: NEDD/DQ demonstrated the ability to maintain accuracy and efficiency in enrollment data management by utilizing an AMR system. The system proactively detected discrepancies, enforced termination rules with precision, and significantly enhanced data integrity. By automating such processes, **NEDD/DQ** ensured a seamless and reliable approach to enrollment data validation.

Strength #2: NEDD/DQ exhibited strength across all five dental service types in urban, middle, and rural counties.

Opportunities for Improvement and Recommendations

Opportunity #1: HSAG did not identify any specific opportunities related to the data collection and management processes **NEDD/DQ** had in place to inform network adequacy standard and indicator calculations. HSAG did not identify any specific opportunities for the calculation of NAV time and distance standards.

Recommendation: N/A

3. Discussion

Conclusions

The SFY 2025 NAV included HSAG's ISCA for each of the four MCEs, as well as independent network capacity and time and distance analyses for specified provider categories. HSAG used the ISCAT and supporting documentation, as well as member and provider data files that each MCE submitted to HSAG, to perform these analyses.

For the ISCA-related activities, the MCEs received *High Confidence* ratings across all the network adequacy indicators assessed.

Overall, all the MCEs demonstrated high performance in meeting the time and distance standards, with all three MCOs meeting the standards in more than 95.0 percent of the provider categories assessed and the DO meeting 100 percent of the standards. This was the first year HSAG considered the MCEs' annual CAPs. HSAG found that each MCE had identified all respective gaps in access that HSAG had discovered during the time and distance analysis and that each MCE had reported these gaps in a CAP to DHHS. The MCOs have opportunities for improvement related to a few pediatric specialists, most notably pediatric ophthalmologists, and to a lesser extent pediatric allergy/immunology specialists and developmental-behavioral pediatricians. The DO succeeded in meeting the time and distance standards for all five of the dental service types across all urban, middle, and rural counties.

For the network capacity analysis, all three of the MCOs met the standards for contracting with OTPs and SUD peer recovery programs, and two of the three MCOs met the standards for residential SUD treatment programs. None of the MCOs met the standards for MLADCs or residential SMI programs.

Analytic Considerations

Various factors associated with the SFY 2025 NAV may affect the validity or interpretation of the results presented in this report, including, but not limited to, the following analytic considerations and data-related caveats:

- Time and distance results summarize the geographic distribution of a provider network relative to member residences and may not fully reflect the availability of providers (or appointments) at given office locations. These general statistics do not consider other issues known to impact access such as whether a specific provider is accepting new Medicaid patients at a specific location or how active the provider is in the Medicaid program.
- When evaluating the results presented in this report, note that provider data supplied by the MCEs may not include providers contracted with the MCEs under limited use contracts or single case agreements.

- DHHS recognizes that the provider list developed for its network capacity standards report template is a living document and contains DHHS' best estimate of the provider landscape using data sources available at a point in time, December 31, 2024. The template may not accurately reflect subsequent movement or changes in provider identity and information. As a result, some MCOs raised concerns about the status of certain providers—questioning whether they are still practicing in New Hampshire, experiencing contracting issues, or lacking an New Hampshire Medicaid ID.
- Discrepancies between the NPI that DHHS included in its list and that the MCOs included in their data, as well as variations in provider or street name spelling, for example, continue to hinder identification of reliable matches between the DHHS list and the MCO data for calculating network capacity results. In multiple instances, the plans supplied an alternate NPI or city/ZIP Code for a provider that appeared valid upon further investigation. Accepting those matches allowed all three plans to meet the OTP standard and led to improved match rates for residential SMI programs, SUD peer recovery programs, and MLADCs, though these rates were still well below the standard. DHHS should continue to improve its methodologies and guidance to the MCOs to promote uniformity in data reporting for use in future reports, and users of this report should interpret these results with caution due to the known issues with defining the denominators and lack of consistency among the MCOs in handling provider data.

Statewide Recommendations

- HSAG recommends that DHHS and the MCEs continue to monitor member access through network adequacy assessments based on the State's expectations.
- DHHS should improve its provider lists for the network capacity standards, using MCO feedback as appropriate to provide the best available list of providers for use in calculating the network capacity indicators. DHHS should review its lists of SUD Master Licensed Alcohol and Drug Counselor (MLADC), opioid treatment provider (OTP), residential SUD treatment program, SUD peer recovery program, and residential serious mental illness (SMI) programs to eliminate providers and programs that are no longer active. DHHS should also provide complete street addresses in its lists to allow the MCOs to be sure they are contracting with all providers and provider locations on the lists. DHHS should consider revising the network capacity standards by providing a clear definition of what constitutes a "willing" provider for the SUD peer recovery program standard.
- DHHS should consider clarifying the standard for MLADCs and listing only individual NPIs. MLADCs are individually licensed and frequently practice in multiple locations or move between treatment programs. They may be covered under individual or facility NPIs, or both, making matching between the DHHS list and MCO data particularly problematic. Clarifying the list to unique individual MLADCs would improve data comparison across MCOs, and reduce the duplication that occurs when a mixture of individual and group provider NPIs are used.
- DHHS should continue to work with HSAG and the MCEs to improve the consistency and quality of reported data. DHHS could provide the MCEs with clear expectations for categorizing providers. DHHS could encourage MCEs to carefully distinguish between individual,

organizational, or facility records for provider types that include both individual and organizational or facility providers.

- DHHS and the MCEs should continue to review provider categories for which the MCEs did not meet the time and distance or network capacity standards, with the goal of determining whether failure to meet the standards was due to a lack of providers, a lack of providers willing to contract with Medicaid in general, or providers unwilling to contract with a given MCE.
- Time and distance standards set a relatively low bar for MCEs to meet, and even the coverage shown in the analysis can be illusory if members are unable to make appointments as needed. Timely access surveys and grievance and appeals data can provide an additional assessment regarding whether the reported networks are meeting member healthcare access needs. HSAG recommends that DHHS continue to measure appointment availability through secret shopper/revealed caller studies.

Appendix A: Network Adequacy Standards

Appendix A presents DHHS' quantitative standards for network adequacy.

MCO Network Adequacy Standards

Time or Distance

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

Table A-1—MCO Provider Time or Distance Standards

Provider Category	Standard[1]
Adult Primary Care (PCP)	At least 90 percent of members must have access to two adult primary care providers (2) within 40 minutes or 15 miles of their residence
Adult Medical Daycare	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Hospice	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Allergist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Audiology	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Cardiologist	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
CAT Scan Provider	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles
Child Primary Care	At least 90 percent of members must have two (2) within forty (40) minutes or fifteen (15) miles
Community Mental Health Program	At least 90 percent of members must have one (1) within forty-five (45) minutes or twenty-five (25) miles
Developmental-Behavioral Pediatrician	At least 90 percent of members must have one (1) within forty-five (45) minutes or twenty-five (25) miles
Durable Medical Equipment (DME)	At least 90 percent of members must have one (1) within sixty (60) minutes or forty-five (45) miles

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

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

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

[1] Time and distance standards represent driving time and driving distance.

Network Capacity Standards

DHHS has set network capacity standards requiring that each MCE contract with a specified percentage of certain provider types licensed and practicing in New Hampshire. Table A-2 presents the provider types and standards to be validated for the network capacity analysis.

Table A-2—MCO Network Capacity Standards

Provider Type	Standard
MLADC	The MCO must contract with at least 70 percent of all such Medicaid-enrolled providers licensed and practicing in New Hampshire as listed by DHHS.
OTP	The MCO must contract with at least 75 percent of opioid treatment programs licensed and practicing in New Hampshire as listed by DHHS.
SUD Peer Recovery Program	The MCO must contract with 100 percent of all such Medicaid-enrolled willing programs in New Hampshire as listed by DHHS.
Residential SMI Program	The MCO must contract with 100 percent of all such programs located in New Hampshire as listed by DHHS.
Residential SUD Treatment Program	The MCO must contract with at least 50 percent of residential SUD treatment programs licensed and practicing in New Hampshire.

Timely Access Standards

DHHS has set timely access standards for MCOs and requires that the MCOs conduct annual surveys and activities to assess whether members have access to care within reasonable time limits. HSAG also conducts Secret Shopper Survey/Revealed Caller Surveys to assess whether members have access to care within the contract standards, with results reported in a separate annual report of that activity. Table A-3 provides the network timely access standards applicable to MCOs. The standards vary by provider category, as indicated.

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

Standard	PCPs	Adult Specialist	Pediatric Specialist	Mental Health (MH) Providers Adult	MH Providers Pediatric	SUD Counselor	SUD Programs
The percentage of providers that make services available for members 24 hours a day and 7 days a week when medically necessary	80%	50%	75%	90%	90%	90%	90%

Standard	PCPs	Adult Specialist	Pediatric Specialist	Mental Health (MH) Providers Adult	MH Providers Pediatric	SUD Counselor	SUD Programs
The percentage of providers that offer hours of operation for Medicaid members that are no less than the hours offered to commercial or Medicaid fee-for-service (FFS) enrollees	100%	100%	100%	100%	100%	100%	100%
The percentage of PCPs that offer after-hours office care in the evenings	N/A	N/A	N/A	N/A	N/A	N/A	N/A
The percentage of PCPs that offer after-hours office care on weekends	N/A	N/A	N/A	N/A	N/A	N/A	N/A
The percentage of providers that offer appointments to Medicaid members for non-symptomatic (i.e., preventive care) office visits within 45 calendar days	90%	50%	75%	N/A	N/A	N/A	N/A
The percentage of providers that offer appointments to standard Medicaid members for non-urgent, symptomatic (i.e., routine care) visits within 10 days (business days for behavioral health and calendar days for non-behavioral health)	100%	70%	70%	60%	60%	80%	80%
The percentage of providers that offer appointments for Medicaid members for urgent, symptomatic conditions within 48 hours	100%	70%	70%	60%	60%	60%	60%
The percentage of behavioral health providers that offer care within six hours for a non-life threatening emergency	N/A	N/A	N/A	40%	40%	40%	40%

Standard	PCPs	Adult Specialist	Pediatric Specialist	Mental Health (MH) Providers Adult	MH Providers Pediatric	SUD Counselor	SUD Programs
The percentage of providers that provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities	100%	100%	100%	100%	100%	100%	100%

N/A means DHHS has not set a threshold for compliance with this standard.

DO Network Adequacy Standards

Time or Distance

The DO is required to submit provider network reports using DHHS-provided report templates. Table A-4 presents the maximum time or distance standards for all provider categories required to report for NAV. Standards differ by type of dental services rather than by type of dental provider, with the allowed time or distance varying by whether a member resides in an urban, middle, or rural county as defined by DHHS.

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

Service/Provider Type	Standard for Urban Counties	Standard for Middle Counties	Standard for Rural Counties
Dental Diagnostic Services	At least 90 percent of members must have one (1) within fifteen (15) minutes or ten (10) miles	At least 90 percent of members must have one (1) within forty (40) minutes or twenty (20) miles	At least 90 percent of members must have one (1) within sixty (60) minutes or thirty (30) miles
Dental Preventive Services	At least 90 percent of members must have one (1) within fifteen (15) minutes or ten (10) miles	At least 90 percent of members must have one (1) within forty (40) minutes or twenty (20) miles	At least 90 percent of members must have one (1) within sixty (60) minutes or thirty (30) miles
Dental Restorative Services	At least 90 percent of members must have one (1) within fifteen (15) minutes or ten (10) miles	At least 90 percent of members must have one (1) within forty (40) minutes or twenty (20) miles	At least 90 percent of members must have one (1) within sixty (60) minutes or thirty (30) miles

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

[1] DHHS standards require that 90 percent of adult members have access to at least one provider within the specified driving time or distance across all service types and county classifications.

N/A means DHHS has not set a threshold for compliance with this standard.

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

Timely Access

DHHS has set timely access standards for the DO and requires that the DO conduct an annual survey and activities to assess whether members have access to care within reasonable time limits. HSAG also conducts Secret Shopper Survey/Revealed Caller Surveys to assess whether members have access to care within the contract standards, with results reported in a separate annual report of that activity. Table A-5 provides the network timely access standards applicable to the DO. The related standards are described with the applicable thresholds, which vary according to whether a provider is a primary dental provider or a dental specialist.

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

Standard	Threshold for Primary Dental Providers	Threshold for Dental Specialists
The percentage of dental providers making services available for members 24 hours a day and 7 days a week when medically necessary	80%	50%

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

[1] Primary dental providers are general dentists. Dental specialists are dentists who have a specialty of oral and maxillofacial surgery. Timely access standards for the DO do not differ by urbanicity.

Appendix B. Methodology

Appendix B describes the DHHS-approved methodology for the SFY 2025 NAV activities, including HSAG's NAV analysis and its ISCA-specific methodology and activities.

ISCA Methodology

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

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

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Virtual Review Validation Activities

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

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

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

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

Network Adequacy Indicator Validation Rating Determinations

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

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

Table B-1—Validation Score Calculation

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

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

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

Table B-2—Indicator-Level Validation Rating Categories

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

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

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

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

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

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

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

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

NAV Methodology

Technical Methods of Data Collection and Analysis

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

Member Data

HSAG requested Medicaid member files from DHHS and from each MCE. HSAG submitted a detailed member data requirements document to DHHS and the MCEs and allowed for a technical assistance call to review the data request in detail and clarify any questions regarding the data request. HSAG requested data for members actively enrolled in an MCE as of December 31, 2024, including these key data elements: member's street address, city, state, ZIP Code, date of birth, dates of enrollment, and MCE affiliation.

Provider Data

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

MCE Provider Network Reports

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

Table B-5—Required Network Reports and Reporting Periods

Report Name and Entity Submitting	Report Frequency	Data Period	Date Submitted to DHHS
MCOs			
Comprehensive Provider Network and Equal and Timely Access Annual Filing	Annual	1/1/2024–12/31/2024	2/14/2025
Corrective Action Plan to Restore Provider Network Adequacy: Annual Template	Annual, and ad hoc if necessary	1/1/2024–12/31/2024	2/14/2025
Access to Care Provider Survey	Annual	7/1/2023–6/30/2024	8/14/2024
DO			
Comprehensive Dental Provider Network and Equal and Timely Access Annual Filing	Annual	2/1/2024–2/29/2024	2/14/2025
Corrective Action Plan to Restore Dental Provider Network Adequacy	Ad hoc if necessary	As applicable	45 days after end of measurement period
Access to Dental Care Provider Survey	Annual	4/1/2024–3/31/2025	5/15/2025

Methods of Analysis and How Conclusions Were Drawn

Time and Distance

For each MCE, HSAG calculated the percentage of members with required access according to the time and distance standards, and evaluated whether 90 percent of members met either the time or distance standard. HSAG used QAS software to calculate the travel time and physical distance between the addresses of specific members for all provider categories identified in the analysis. HSAG also visually compared its results to MCE-submitted results included in the Network.01 and Dental Network.01 reports for general consistency and reasonability.

Network Capacity

For the five SUD provider types evaluated in this study, HSAG compared provider MCE-submitted data files to the DHHS-submitted SUD provider lists as shown in Table B-6. For each provider listed in the DHHS-submitted file, HSAG assessed the extent to which every MCE-submitted provider record matched the listed provider information. For each listed provider and each submitted provider record, HSAG calculated a matching score based on NPI, provider name, city, county, state, and ZIP Code. HSAG identified exact matches for NPI, provider name, and location fields. HSAG also evaluated provider names using approximate matching to account for minor differences in spelling or formatting, which resulted in lower match scores. This scoring approach helped quantify the strength of each potential match.

To guide match decisions, HSAG used a structured approach that prioritized stronger matches—those with agreement across key fields: NPI, provider name, and location. HSAG assigned matches with exact alignment across all fields the highest priority while considering those with fewer or less precise matches as lower priority. This hierarchy helped ensure that HSAG selected the most reliable and complete matches for each provider.

Using a combination of these priority levels and the match score, HSAG identified the submitted provider record most closely resembling the listed provider and determined whether it should consider the submitted record a match. Although the DHHS file did not include a dedicated address field, HSAG leveraged any additional descriptive information, such as building names or location references embedded in the provider name, to help refine match decisions. These contextual clues were especially useful in identifying more precise address matches.

Table B-6—MCE Provider Capacity Standards

Provider Type/Service	Requirement
MLADC	The MCO must contract with at least 70 percent of all such Medicaid-enrolled providers licensed and practicing in New Hampshire as listed by DHHS.
OTP	The MCO must contract with at least 75 percent of opioid treatment programs licensed and practicing in New Hampshire as listed by DHHS.
SUD Peer Recovery Program	The MCO must contract with 100 percent of all such Medicaid-enrolled willing programs located in New Hampshire as listed by DHHS.
Residential SMI Program	The MCO must contract with at least 100 percent of all such programs located in New Hampshire as listed by DHHS.
Residential SUD Treatment Program	The MCO must contract with 50 percent of residential SUD treatment programs licensed and practicing in New Hampshire as listed by DHHS.

Appendix C. HSAG Validation Team and List of Interviewees

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

Table C-1 lists the **ACNH** staff members interviewed by the HSAG validation team.

Table C-1—List of ACNH Interviewees

Interviewee Name	Title
Lisa Pettengill	Director, Compliance
Chanthy Yoeun-Eirng	Manager, Analytics Product
Bill Keena	Market President
Shane O'Neill	Business Specialist, Regulatory Reporting
Trina Loughery	Director, Operations and Administration
Nancy Bevens	Director, Provider Network Operations
Susan Adams	Director, Claims
Arlene Wiseman	Director, Pharmacy
Thomas Christian	Director, Provider Enrollment
Jarrod Barshinger	Senior Analyst, Plan Analytics
Roland Stone	Director, Provider Network Management
Angela Bankston	Corporate Director, Utilization Management (UM) Operations Manager, Provider Enrollment Services
Anita Gregoire	Reporting Analyst, Contact Center
Octavia Philips	Director, Pharmacy
Raghu Gonihalli	Director, Information Systems Development Management
Marva Gelzer	Director, Contact Center Operations
Nathan Gillin O'Hanlon	Manager, Appeals and Grievances
Lizette Cordero	Analyst, Business Systems Enterprise Operations
Lisa Spiers	Supervisor, Care Management
Ken Franklin	Lead Developer Programmer
Chaitanya Tumuluri	Manager, Information Systems
Javier Muniz	Director, Non-Emergent Medical Transportation Services
Jenn Wynn	Manager, Client Management
Amber Slusher	Manager, Client Management
Jordan Zumaeta	Data Analyst

Table C-2 lists the **NHHF** staff members interviewed by the HSAG validation team.

Table C-2—List of NHHF Interviewees

Interviewee Name	Title
Amphawan Soisak	Data Analyst III
Ashley Johnson	Director, Market Engagement
Caryn-Ann Ferriter	Quality Improvement (QI) Specialist II
Charlie Fernandez	Business Analyst I
Dawn Tomlinson	Business Analyst III
Janny Jones	Manager, Clinical Operations
Joann Kavana	Senior Director, Population Health & Clinical
Jodi Doody	Manager, QI
Jonathan Morello	Vice President, Population Health & Clinical
Joseph Montella	Manager, Data Analytics & Reporting
Joseph Smith	Business Analyst III (Healthcare Analytics)
Jun Lee	Lead Solutions Architect
Laura Hayes	Manager, Compliance
Linda Ruth	Director, QI
Mallory Proctor	Senior Director, Healthcare Analytics
Marisol Alejandro	Senior IT Assurance Analyst
Megan Melanson	Director, Behavioral Health Services
Rosemary Garcia	Customer Service Advocate IV
Amy Foye	Senior Manager of Operations
Karrie Ezequelle	Manager, Claims & Contract Support Services
Ryan Schuette	Manager, Behavioral Health Utilization
Laura Futo	Director, Behavioral Health Utilization
Kate White	Data Analyst IV
Katie Wilson	Director, Encounters
Rakesh Veeramachaneni	Senior Data Analyst
Amanda English	Medical Transportation Management
Aaron Bailes	Medical Transportation Management
Joshua Grant	Data Analyst III
Lisa Carmichael	Director, Grievance & Appeals
Cathryn Spinney	Business Analyst II
Luisa Casuccio	Evolent
Samatha Marino	Evolent

Table C-3 lists the **WS** staff members interviewed by the HSAG validation team.

Table C-3—List of WS Interviewees

Interviewee Name	Title
Allison Deptula	Medicaid Program Operations Manager
Melanie Fredette	Senior Regulatory Reporting and Resolution Associate
Cheryl Nicum	Medicaid Program Coordinator
Michael Comerford	Director, Medicaid & Medicare Compliance
Kelli Accardi	Behavioral Health Program Manager
Jacqueline Bigbee	Senior Director of Member Appeals and Grievances
Barbara Costello	Director of UM, Clinical Programs
Danny Sharpe	Senior Director of Quality Analytics, Compliance, & Audit
Sherri-Ann De Mederios	Director of Provider Data Integrity
Tina Dietrich	Manager, Supplier Relationship Management
Felicia DiSciscio	Manager of Appeals and Grievances
Cory Ann Dugan	UM Regulatory Program Manager
Holly Eaton	Director of Contracting & Provider Engagement
Ophelia Gibson	Senior Health Data Analyst
Janae Hagel	Project Coordinator
Kevin Hartson	Regulatory Reporting Analyst
Emily Hinderman	Director of Claims, Member Enrollment and Provider Appeals
Lisa Ladd	Senior Manager, Quality Data and Analytics
Luis Leon	Provider Data Analyst
Stacy McCloskey	Manager, Network Operations
Danielle Murphy	Operations Manager, Transportation
Alicia Oliveria	UM Special Projects Manager
Phuong Pham	Senior Director of Pharmacy Services
Casandra Randall	Director of Customer Care
Runona Rodriguez	Operations Manager, Member and Provider Service
Tara Saini	Director of Clinical & Payment Analytics
Steven Silver	Director—Applications
Jasmine Stone	Audit & Compliance Manager, Pharmacy
Stephanie Sy	Third Party Vendor, Pharmacy Services
Ruthanne Waite	Senior IT Data Analyst
Jennifer Zhong	Director of Value Based Payment Analytics

Table C-4 lists the **NEDD/DQ** staff members interviewed by the HSAG validation team.

Table C-4—List of NEDD/DQ Interviewees

Interviewee Name	Title
Tracy Gilman	Director, Government Programs, NorthEast Delta Dental (NEDD)
Matt Wilcox	Technical Lead, Information Services Operations, NEDD
Pat Whelan	Senior Client Partner, DentaQuest
Mike Duhamel	Director, Member Enrollment and Benefits, DentaQuest
Dylan Normandin	Business Systems Analyst, Enrollment, DentaQuest
David Edgar	Director, Workforce Management, DentaQuest
Leslie Bailey	Associate Director, Business Intelligence & Reporting, DentaQuest
Nicole Mantanye	Director, Provider Network Intelligence, DentaQuest
Talia Rodgers	Senior Manager, Business Analytics, DentaQuest
Hazel Mendez	Senior Manager, Provider Partner, DentaQuest
Liza Morris	Associate Director, Provider Operations, DentaQuest
Deseray Backman	Credentialing Delegation Auditor Consultant, DentaQuest
Megan Stephen	Senior Manager, Client Data Applications, DentaQuest
Adrianna Dykstra	Senior Manager, Complaints & Grievances, DentaQuest
Patrick Joyner	Senior Manager, Appeals, DentaQuest
Amber Gottheardt	Senior Manager, Appeals, DentaQuest
Marina Pyatkes	Claim Audit Analyst, DentaQuest

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

Table C-5—HSAG Validation Team

Name and Title	Role
Elisabeth Hunt, MHA, CHCA *Executive Director, Data Science & Advanced Analytics (DSAA)*	Certified Healthcare Effectiveness Data and Information Set (HEDIS®)[3] Compliance Auditor (CHCA); multiple years of auditing experience with expertise in data integration, information systems, provider data, network adequacy validation, and performance measure development and reporting.

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

Name and Title	Role
Rachael French, CHCA *Associate Director, Audits, DSAA*	CHCA; multiple years of auditing experience with expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review, and analysis, provider data, and network adequacy source data and validation.
Cindy Strickland *Associate Director, NAV, DSAA*	Subject matter expertise in network adequacy data, analysis, and reporting. Task lead for New Hampshire NAV activities since SFY 2023, and analytics auditor for SFY 2025 **NHHF** and **WS** ISCA virtual reviews.
Janice Brown, MBA, LMSW, CCM *Senior Manager, Audits, DSAA*	Subject matter expertise in managed care, quality measure reporting, QI, network adequacy knowledge, data integration, systems review and analysis, and NAV.
Cynthia Anderson, MPH *Analytics Manager III, DSAA* *Project Lead, Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, network adequacy knowledge, data integration, systems review and analysis, and NAV.
Tamieka Square, MHA *Auditor I, DSAA* *Task Lead, Secondary Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, network adequacy knowledge, data integration, systems review and analysis, and NAV.
Angela Farris *Auditor I, DSAA* *Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, network adequacy knowledge, data integration, systems review and analysis, and NAV.
Sumayyah Hackett *Auditor I, DSAA* *Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, network adequacy knowledge, data integration, systems review and analysis, and NAV.
Adrianna Ancillo *Associate Analytics Manager, DSAA* *Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, network adequacy knowledge, data integration, systems review and analysis, and NAV. Analytics auditor for SFY 2025 **ACNH** and **NEDD/DQ** ISCA virtual reviews.

Appendix D. MCO Statewide Comparative Results

Appendix D presents tables with comparative results across MCOs for time and distance standards and network compacity standards.

Statewide Time and Distance Results by MCO

Table D-1 displays the percentage of each MCO's members who had the access to care required by contract standards for all applicable provider categories, by MCO. However, DHHS is aware that the MCOs have not been able to meet these standards and have submitted CAPs for improving the timely access standard rate.

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

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Primary Care							
Primary Care, Adult	Adults	100%	>99.9%	100%	99.9%	100%	>99.9%
Primary Care, Pediatric	Children and adolescents	100%	>99.9%	100%	>99.9%	100%	>99.9%
Physician Specialists							
Allergist, Adult	Adults	99.5%	97.5%	99.9%	97.7%	95.6%	94.0%
Allergist/Immunologist, Pediatric	Children and adolescents	82.0%^	79.5%^	98.8%	93.5%	78.2%^	72.1%^
Audiologist, Adult	Adults	100%	100%	100%	100%	100%	100%
Audiologist, Pediatric	Children and adolescents	100%	100%	100%	100%	100%	100%
Cardiologist, Adult	Adults	100%	100%	100%	100%	100%	100%
Cardiologist, Pediatric	Children and adolescents	100%	100%	100%	100%	100%	100%
Dermatologist, Pediatric	Children and adolescents	>99.9%	98.1%	>99.9%	97.2%	>99.9%	98.1%
Endocrinologist, Pediatric	Children and adolescents	100%	99.5%	>99.9%	99.3%	>99.9%	99.4%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Gastroenterologist, Pediatric	Children and adolescents	100%	99.5%	>99.9%	97.2%	>99.9%	98.3%
General Surgeon	All members	100%	100%	100%	100%	100%	100%
Neurologist, Adult	Adults	100%	100%	100%	100%	100%	100%
Neurologist, Pediatric	Children and adolescents	>99.9%	99.4%	100.0%	100.0%	>99.9%	99.4%
Obstetrician/ Gynecologist or Other Maternity Provider	Females, ages 13 and older	100%	100%	100%	100%	100%	100%
Oncologist, Adult	Adults	100%	100%	100%	100%	100%	>99.9%
Ophthalmologist, Adult	Adults	97.8%	97.1%	99.9%	99.2%	99.9%	99.6%
Ophthalmologist, Pediatric	Children and adolescents	77.7%^	72.9%^	0.0%^	0.0%^	100%	100%
Optometrist	All members	100%	>99.9%	100%	100%	98.5%	97.3%
Orthopedic Surgeon, Pediatric	Children and adolescents	>99.9%	98.1%	100%	98.1%	100%	100%
Orthopedist, Adult	Adults	100%	100%	100%	100%	100%	100%
Orthopedist, Pediatric	Children and adolescents	>99.9%	98.1%	100%	100%	100%	100%
Otolaryngologist, Adult	Adults	100%	100%	100%	100%	100%	100%
Otolaryngologist, Pediatric	Children and adolescents	>99.9%	98.1%	98.8%	92.3%	100%	100%
Pediatrician, Developmental-Behavioral	Children and adolescents	76.0%^	54.5%^	91.4%	78.0%	82.7%^	55.1%^
Plastic Surgeon, Adult	Adults	95.4%	93.7%	99.3%	98.8%	95.6%	93.6%
Plastic Surgeon, Pediatric	Children and adolescents	>99.9%	99.6%	100%	100%	>99.9%	99.6%
Podiatry, Adult	Adults	100%	100%	100%	100%	100%	100%
Psychiatrist, Adult	Adults	100%	99.9%	100%	100%	97.0%	82.4%
Psychiatrist, Pediatric	Children and adolescents	100%	100%	100%	99.4%	100%	100%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Psychologist	All members	99.9%	98.8%	100%	>99.9%	99.9%	97.5%
Thoracic Surgeon, Adult	Adults	95.9%	93.8%	94.5%	93.3%	96.1%	95.4%
Urologist, Adult	Adults	100%	100%	100%	>99.9%	100%	100%
Urologist, Pediatric	Children and adolescents	>99.9%	98.7%	>99.9%	97.2%	>99.9%	98.1%
Hospital Services							
Hospital—General Acute Care	All members	100%	100%	100%	100%	100%	>99.9%
Hospital—Maternity	Females, ages 13 and older	100%	>99.9%	99.9%	99.2%	>99.9%	99.7%
Hospital—Level 3/4 Neonatal Intensive Care	All members	>99.9%	98.2%	>99.9%	97.2%	>99.9%	98.1%
Hospital—Level 1 Major Trauma Treatment	All members	>99.9%	98.2%	100%	100%	>99.9%	98.1%
Hospital—Diagnostic Cardiac Catheterization	All members	98.5%	97.4%	98.0%	95.0%	>99.9%	99.6%
Hospital—Open-Heart Surgery Services	All members	>99.9%	98.2%	>99.9%	97.2%	>99.9%	98.1%
Hospital—Therapeutic Radiation	All members	95.8%	93.8%	93.1%	91.6%	100%	98.3%
Hospital/Short Term Facility for Inpatient Medical Rehabilitation Services	All members	100%	100%	100%	99.6%	100%	100%
Short Term Care Facility for Involuntary Psychiatric Admissions	All members	95.2%	93.4%	93.1%	91.4%	93.5%	90.6%
General Inpatient Psychiatric	All members	99.2%	96.5%	98.8%	96.3%	100%	99.2%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
Diagnostic Services							
CAT Scan Provider	All members	100%	100%	100%	100%	100%	100%
Imaging Provider (Ultrasound & X-Ray) Provider	All members	100%	100%	100%	100%	100%	100%
Magnetic Resonance Imaging Center	All members	100%	100%	100%	100%	100%	100%
Laboratory	All members	100%	100%	100%	100%	100%	100%
Other Facilities and Services							
Pharmacy	All members	100%	99.6%	100%	99.5%	100%	99.8%
DME	All members	100%	>99.9%	100%	>99.9%	100%	100%
Adult Medical Daycare	Adults	99.4%	96.0%	98.7%	93.6%	99.3%	95.1%
Family Planning	All members, ages 13 and older	100%	100%	100%	100%	98.2%	96.1%
Licensed Renal Dialysis Provider	All members	99.0%	96.3%	100%	>99.9%	100%	>99.9%
Office Based Physical Therapist/Occupational Therapist/Speech Therapist	All members	100%	100%	100%	100%	100%	100%
Community Mental Health Program	All members	>99.9%	99.6%	100%	99.7%	100%	99.5%
Hospice	Adults	99.9%	99.6%	99.9%	99.2%	99.9%	99.6%
Hospice	All members	99.9%	99.6%	99.9%	99.3%	>99.9%	99.6%
Substance Use Disorder (SUD) Services							
SUD Master Licensed Alcohol & Drug Counselor	All members	100%	98.8%	99.3%	91.7%	99.9%	89.5%
Methadone Clinics	All members	95.4%	93.9%	93.8%	92.2%	95.5%	94.4%

		Percent of Members With Access Within Time or Distance Standards					
		ACNH		NHHF		WS	
Provider Category	Member Population	Time	Distance	Time	Distance	Time	Distance
SUD Comprehensive Program	All members	99.9%	99.7%	99.9%	99.5%	95.6%	94.4%
SUD Outpatient Program	All members	100%	>99.9%	100.0%	99.9%	98.3%	97.5%

^ The MCO did not meet minimum time and distance standards for this provider category, but addressed the result in its CAP to Restore Provider Network Adequacy.

Statewide Network Capacity Analysis Results by MCO

Table D-2 displays the statewide network capacity analysis results for MLADCs as identified by unique NPI (i.e., the percentage of unique providers licensed and practicing within New Hampshire and listed by DHHS that could be identified in the MCO's provider data file). DHHS has determined that this indicator will be viewed for informational purposes only this year.

Table D-2—Statewide Network Capacity Analysis Results for MLADCs by MCO

MCO	DHHS Standard	Number (%) of Listed Programs Contracted	Additional MLADCs Contracted With the MCO
ACNH	70% of 184 unique providers	78 (42.4%)	46
NHHF	70% of 184 unique providers	36 (19.6%)	15
WS	70% of 184 unique providers	14 (7.6%)	25

Table D-3 displays the statewide network capacity analysis results for OTPs by MCO (i.e., the percentage of providers licensed and practicing within New Hampshire and listed by DHHS that could be identified in the MCO's provider data file).

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

MCO	DHHS Standard	Number (%) of Listed Programs Contracted
ACNH	75% of 10 listed providers	10 (100%)
NHHF	75% of 10 listed providers	9 (90.0%)
WS	75% of 10 listed providers	10 (100.0%)

Table D-4 displays the statewide network capacity analysis results for SUD peer recovery programs by MCO (i.e., the percentage of providers licensed and practicing within New Hampshire and listed by DHHS that could be identified in the MCO's provider data file).

Table D-4—Statewide Percentage of SUD Peer Recovery Programs by MCO

MCO	DHHS Standard	Number (%) of Listed Programs Contracted
ACNH	100% of willing programs listed*	11 (100%)
NHHF	100% of willing programs listed*	12 (100%)
WS	100% of willing programs listed*	9 (100%)

* For this report, DHHS has interpreted a willing program to be one from DHHS' list that has entered a contract with the MCO and therefore appears in its provider data.

Table D-5 displays the statewide network capacity analysis results for residential SMI programs by MCO (i.e., the percentage of providers licensed and practicing within New Hampshire and listed by DHHS that could be identified in the MCO's provider data file

Table D-5—Statewide Percentage of Residential SMI Programs by MCO

MCO	DHHS Standard	Number (%) of Listed Programs Contracted
ACNH	100% of 12 listed* programs	8 (66.7%)^
NHHF	100% of 12 listed* programs	8 (66.7%)^
WS	100% of 12 listed* programs	8 (66.7%)^

* Seven residential SMI programs operated by NFI North were removed from the denominator for network capacity standards, as they are not residential SMI programs.

^ The MCO did not meet minimum network capacity standards for this provider category.

Table D-6 displays the statewide network capacity analysis results for residential SUD treatment programs by MCO (i.e., the percentage of providers licensed and practicing within New Hampshire and listed by DHHS that could be identified in the MCO's provider data file).

Table D-6—Statewide Percentage of Residential SUD Treatment Programs by MCO

MCO	DHHS Standard	Number (%) of Listed Programs Contracted
ACNH	50% of 17 listed* programs	14 (82.4%)
NHHF	50% of 17 listed* programs	11 (64.7%)
WS	50% of 17 listed*programs	4 (23.5%)^

*DHHS learned that some of its listed residential SUD treatment programs have elected not to contract with Medicaid, and DHHS' list will be amended for 2026 to reflect this information. HSAG reviewed the impact of removing these providers from this 2025 analysis, and found that while a potential reduction in denominator would have resulted in changes in the MCOs' percentage of provider or programs contracted, it would not have changed the overall met/not met results for any MCO this year. Accordingly, the number of DHHS-listed residential SUD treatment programs was not changed for this report.

^ The MCO did not meet minimum network capacity standards for this provider category.

Appendix E. MCE Recommendations Requiring Follow-Up

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

ACNH

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

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

ACNH EQRO Findings/Recommendations for Improvement to Include in the EQRO.01 Report		
NAV Report		
1	ACNH-2025-EQRO.01_NA-01	**ACNH** did not meet the 90 percent time and distance standards for three pediatric provider categories: allergist/immunologist, pediatric; pediatrician, developmental-behavioral; and ophthalmologist, pediatric. **Recommendation:** HSAG recommends that **ACNH** maintain current levels of access to care and continue to address network gaps for pediatric allergists/immunologists, developmental-behavioral pediatricians, and pediatric ophthalmologists.
2	ACNH-2025-EQRO.01_NA-02	**ACNH** did not meet the relevant network capacity standards for residential SMI programs. **Recommendation:** HSAG recommends that **ACNH** maintain current levels of access to care and continue to improve the percentage of DHHS-listed providers with which it contracts to provide all services covered by the network capacity standards, especially for residential SMI programs.

NHHF

Table E-2 lists opportunities for improvement to include in the QAPI report for **NHHF**.

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

NHHF EQRO Findings/Recommendations for Improvement to Include in the EQRO.01 Report		
NAV Report		
1	NHHF-2025-EQRO.01_NA-01	**NHHF** did not meet the 90 percent time and distance standards for one provider category: ophthalmologist, pediatric. **Recommendation:** HSAG recommends that **NHHF** maintain current levels of access to care and continue to address network gaps for pediatric ophthalmologists.
2	NHHF-2025-EQRO.01_NA-02	**NHHF** did not meet the relevant network capacity standards for residential SMI programs. **Recommendation:** HSAG recommends that **NHHF** maintain current levels of access to care and continue to improve the percentage of DHHS-listed providers with which it contracts to provide all services covered by the network capacity standards, especially for residential SMI programs.

WS

Table E-3 lists opportunities for improvement to include in the QAPI report for **WS**.

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

WS EQRO Findings/Recommendations for Improvement to Include in the EQRO.01 Report		
NAV Report		
1	WS-2025-EQRO.01_NA-01	**WS** did not meet the 90 percent time and distance standards for two pediatric provider categories: allergist/immunologist, pediatric and pediatrician, developmental-behavioral. **Recommendation:** HSAG recommends that **WS** maintain current levels of access to care and continue to address network gaps for pediatric allergists/immunologists and developmental-behavioral pediatricians.
2	WS-2025-EQRO.01_NA-02	**WS** did not meet the relevant network capacity standards for two provider types: residential SMI programs, and residential SUD treatment programs. **Recommendation:** HSAG recommends that **WS** maintain current levels of access to care and continue to improve the percentage of DHHS-listed providers with which it contracts to provide all services covered by the network capacity standards, especially for residential SMI programs, and residential SUD treatment programs.

NEDD/DQ

Table E-4 lists opportunities for improvement to include in the QAPI report for **NEDD/DQ**.

HSAG did not identify any opportunities for improvement related to **NEDD/DQ**'s data collection and management processes to inform network adequacy standard and indicator calculations or for the calculation of NAV time and distance standards.

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

NEDD/DQ EQRO Findings/Recommendations for Improvement to Include in the Dental_EQRO.01 Report
NAV Report
There are no findings/recommendations from the SFY 2025 NAV Report that need to be included in the DENTAL_EQRO.01 Report.