State of Nevada

State Fiscal Year 2014–2015
Provider Network Access Analysis

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HSAG HEALTH SERVICES ADVISORY GROUP

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HSAG HEALTH SERVICES ADVISORY GROUP

1. Executive Summary

Introduction

At the request of the Division of Health Care Financing and Policy (DHCFP), Health Services Advisory Group (HSAG) conducted an evaluation of Nevada's Medicaid provider network. The purpose of the analysis was to estimate the provider network capacity, geographic distribution, and appointment availability of the managed care organizations' (MCOs) and fee-for-service (FFS) networks. This report shows a comparison among these three dimensions, by provider type, for Amerigroup (AGP), the Health Plan of Nevada (HPN), and the FFS Program relative to the State of Nevada's general population. The analysis evaluated three dimensions of access and availability:

- **Capacity** – provider-to-recipient ratios for Nevada's provider networks
- **Geographic Network Distribution** – time/distance analysis for applicable provider specialties and average distance (miles) to the closest provider
- **Appointment Availability** – average length of time (number of days) to see a provider for MCOs and FFS

Although the evaluation metrics are easily described, many factors impact the effectiveness of the following analyses which are beyond the DHCFP's ability to measure or control. As a result, the following study represents one of many ongoing attempts to capture, report, monitor, and explore the *experience* of Medicaid recipients' access to health care services.

Taken individually, the dimensions of access and availability described above are incomplete. Instead, evaluation of network adequacy should encompass all three dimensions in order to understand the impact of both network infrastructure and the implementation and actions of that infrastructure. While individual dimension results are important, the interaction of provider capacity and geographic distribution along with appointment availability provide a comprehensive picture of the adequacy of Nevada's Medicaid provider networks.

Methodology

The network analysis results presented in this report were based on comparative evaluations of both Nevada Medicaid recipients and the providers who serve them. Additionally, comparison groups, or populations, of Nevada residents and providers were also defined to evaluate network performance relative to the general population in Nevada. To complete the provider network access analysis, HSAG obtained Medicaid member information (including enrollment and demographics) and provider information (including facility location and physician specialty) from the DHCFP and its two MCOs—i.e., AGP and HPN. In addition, HSAG worked in collaboration with DHCFP to obtain general population counts from the U.S. Census Bureau and provider information from the National Plan and Provider Enumeration System (NPPES). It is important to note that limitations in the quality of and access to valid provider information limit the ability to render conclusions regarding the *adequacy* of the Medicaid provider network.

Following the procurement of recipient and provider data; HSAG cleaned, processed, and prepared the recipient and provider data for the analysis. All general population, Medicaid recipient, and provider files were standardized and geo-coded using the Quest Analytics software. See Section 3 (Methodology) and Appendix A for a full description of the study methodology, and Section 7 (Study Limitations) for a description of the factors affecting the assessment of network adequacy.

The Nevada Provider Network Analysis evaluates three dimensions of the provider access and availability—i.e., provider capacity, geographic network distribution, and appointment availability. Taken together, these three analyses provide insight into the underlying network infrastructure as well as its application and interaction with Nevada's Medicaid population. A brief description of the study analyses are presented below:

- **Provider Capacity Analysis:** In order to assess the capacity of a given provider network, HSAG compared the number of providers associated with an MCO's or FFS' provider network relative to the number of assigned recipients. This provider-to-recipient ratio (provider ratio) represents a summary statistic used to highlight the overall capacity of a plan's or program's provider network to deliver services to Medicaid recipients.
- **Geographic Network Distribution Analysis:** The second dimension of this study evaluates the geographic distribution of providers relative to recipient populations. HSAG calculated two spatial-derived metrics: (1) percentage of recipients within predefined access standards, and (2) the average distance and travel time to the nearest provider.
- **Appointment Availability Analysis:** To evaluate appointment availability, HSAG conducted a secret shopper telephone survey of providers' offices to evaluate the average length of time it takes for a Medicaid recipient to schedule an appointment with a Nevada-licensed provider. Both contracted MCOs and the FFS program were included in the sampling process and surveyed by telephone to evaluate the availability of appointments and whether that availability met the DHCFP/MCO contract standards.

Findings

Provider Capacity Findings

In general, the results from the provider ratio analysis suggest the Medicaid program in Nevada maintains an extensive provider network across the FFS and MCOs for primary care physicians, most specialists, and the majority of facilities. However, the results also highlight several areas where MCO provider ratios were higher than Nevada's general population. The DHCFP should work with the MCOs to determine, where appropriate, if additional providers in these categories are required to address the needs of the population. Key findings from the report include the following:

- Medicaid provider ratios for PCPs and PCP Extenders across FFS, AGP, and HPN were substantially better than the ratio standards set forth in the Medicaid MCO contract (i.e., 1:1,500 and 1:1,800, respectively). Additionally, the provider ratios for FFS, AGP, and HPN were better than the provider ratio reported for the general population in Nevada.

- Medicaid provider ratios for Dentists across FFS, AGP, and HPN exceeded the ratio standards set forth by the DHCFP/MCO contract (i.e., 1:1,500). Additionally, the provider ratio for FFS was much lower than the provider ratios reported for Nevada's general population, AGP, and HPN.
- For the other provider specialty categories [see Section 4 (Findings)], the ratios for FFS, AGP, and HPN were generally lower than the provider ratios reported for the general population except for two provider categories—i.e., pediatric mental health specialist for AGP and mental health outpatient services for HPN. In every other case, the results indicate a diversified specialist network is available to Medicaid recipients when compared to the general population.
- The facility and specialty provider ratios for FFS, AGP, and HPN were also lower than the respective provider ratios for the general population. There were only four instances where the MCO ratios exceeded the general population provider ratios—i.e., home health and psychiatric inpatient hospitals for AGP; and home health and psychiatric inpatient hospitals for HPN. In all but one case (AGP's psychiatric inpatient hospital ratio), there were more than 10,000 extra recipients per provider.

Geographic Network Distribution Findings

The results from the geographic network distribution analysis suggest that the Medicaid program in Nevada maintains a geographically accessible provider network across FFS and the MCOs for primary care physicians, most specialists, and the majority of facilities in the urban/suburban locations. However, average driving time and distance in rural locations for the FFS population continues to exceed that reported by the general population and the MCOs. Ongoing monitoring by DHCFP and the MCOs is important to maintain and maximize the physician network in rural Nevada. Key findings from the report include the following:

- Overall, more than 99.9 percent of AGP, HPN, and FFS recipients in the urban and suburban areas resided within the distance-based access standards for PCPs and PCP Extenders (i.e., 25 miles) with 100 percent of the general population and FFS (PCP category only) within 25 miles of the nearest provider.
- At least 99.5 percent of recipients enrolled with the MCOs were located within 25 miles of the nearest provider regardless of whether it was an urban/suburban or rural area.
- In rural areas, the percentage of recipients residing within the distance-based access standard for PCPs remained high for AGP and HPN (99.5 percent and 99.6 percent, respectively) while the general population and FFS percentages were somewhat lower (91.9 percent and 92.9 percent, respectively).
- The average drive time to the nearest PCP or PCP Extender was approximately 10 minutes or less across all populations with average drive times ranging from 1.9 minutes to the nearest PCP for FFS and the general population (urban/suburban locations) to 11.2 minutes to the nearest PCP Extender for FFS (rural locations).
- The average time to the nearest primary care provider (both PCPs and PCP Extenders) in urban/suburban locations (2.3 minutes) is shorter than the average time to the nearest primary care provider in a rural location (5.9 minutes).

- The average time to a specialty provider in an urban/suburban setting was 10.1 minutes compared to 31.0 minutes to a specialty provider in a rural area. Moreover, Medicaid recipients experienced a shorter drive time across all specialty providers overall (18.8 minutes on average) compared to the general population (26.7 minutes, on average).
- There was a notable difference in the average drive time to a facility between Medicaid recipients and the general population (32.7 minutes and 22.7 minutes, respectively). There were also notable differences in the drive times to facilities in rural (40.8 minutes) and urban/suburban locations (22.4 minutes).
- In general, average driving distance results mirrored the results of average drive time. See Section 4 (Findings) for additional information.
- Overall, differences in travel distance between the general population, FFS, and the MCOs were smaller in urban/suburban locations compared to rural locations where the general population and FFS had longer driving distances. This finding is likely the result of the larger proportion of rural recipients comprising FFS and the general population.

Appointment Availability Findings

Overall, the results from the secret shopper survey suggest that while the Medicaid provider network infrastructure is robust, the engagement of providers represents an area for improvement. Across the four categories evaluated in this study (i.e., PCPs, prenatal care providers, specialists, and dentists), nearly 50 percent of all outreach calls failed to secure appointments (47.6 percent); and of those calls that ended in an appointment, less than three-quarters (69.4 percent) were scheduled within contract standards. Table 1-1 summarizes the results for the secret shopper surveys.

Table 1-1—Appointment Availability Results

Specialty Category	Valid Cases	Unable to Schedule Appointment		Able to Schedule Appointment		Appointments within Compliance Standards	
		Number	Percent	Number	Percent	Number	Percent
PCP	208	85	40.9%	123	59.1%	73	59.3%
Prenatal Care							
First and Second Trimester	144	86	59.7%	58	40.3%	14	24.1%
Third Trimester	144	90	62.5%	54	37.5%	10	18.5%
Specialist	288	163	56.6%	125	43.4%	108	86.4%
Dentist	288	86	29.9%	202	70.1%	185	91.6%
Total	**1,072**	**510**	**47.6%**	**562**	**52.4%**	**390**	**69.4%**

These results indicate the need for ongoing monitoring by DHCFP and the MCOs in order to maximize the physician network in Nevada. Specific appointment availability results by specialty provider category are presented below.

Primary Care Providers

- Among PCPs providing services to adults, callers were able to schedule appointments for 56.7 percent of cases, although this percentage varied by 18.9 percentage points across MCO/Program.
- Of the 71 cases in which an appointment could not be scheduled, 23 cases (32.4 percent) were due to the caller being unable to reach the appointment scheduling staff, and 21 cases (29.6 percent) were due to the PCP no longer being contracted with the health plan.
- Overall, 11.3 percent of incomplete appointments resulted from providers requiring preliminary actions by the caller before scheduling an appointment, including designating the provider as the caller's PCP, completing paperwork, or registering on the internet with the provider's office.

Prenatal Care Providers

- In general, callers were only able to schedule appointments in approximately 40 percent of the calls when presenting themselves as women in their first or second trimester of pregnancy, with some variation noted across MCO/Program.
- Primary reasons for incomplete appointments for women in their first and second trimester of pregnancy involved the physician offices requiring pre-appointment screenings (29.1 percent) and callers being unable to reach appointment scheduling staff (18.6 percent).
- Overall, the average time to schedule a prenatal appointment for women in the first or second trimester of pregnancy was 20 calendar days, with individual MCO/Program results ranging from 0 to 22 calendar days. Overall, only 24.1 percent of appointments were in compliance with contractual standards, though the percentage of appointments in compliance with appointment availability standards varied by 34.6 percentage points across the MCOs and the FFS program.
- Overall, callers were able to schedule appointments with 37.5 percent of prenatal care providers for women in their third trimester of pregnancy, and this percentage varied across the MCOs and the FFS program, ranging from 31.3 percent for FFS to 45.8 percent for AGP.
- Primary reasons for incomplete appointments included providers requiring pre-appointment screenings (41.1 percent), providers with panel restrictions (16.7 percent), and callers being unable to reach appointment scheduling staff (12.2 percent).
- Overall, only 54 of the 144 outreach calls to prenatal care providers (37.5 percent), resulted in an appointment for a woman in the third trimester of pregnancy, and the average wait time for an appointment was 16 calendar days.

Specialists

- Overall, callers were able to successfully schedule an appointment with a specialist provider for 43.4 percent of valid cases. The percentage of completed appointments varied minimally across the MCOs and the FFS program, ranging from 41.7 percent for HPN to 45.8 percent for FFS.

- Primary reasons callers identified for incomplete appointments included being unable to reach appointment scheduling staff (39.3 percent) or the provider requiring a referral from another provider prior to scheduling an appointment (34.4 percent).
- At 15 calendar days, the average time to an appointment with a specialist was below the appointment availability standard, and MCO/Program results had a range of nine calendar days. Overall, 86.4 percent of cases offered an appointment within 30 days, though this percentage varied widely across the MCOs and the FFS program (15.7 percentage points).

Dentists

- Overall, callers were able to successfully schedule a dental appointment with 70.1 percent of valid providers in the dental sample. Individual performance by plans varied, with the lowest number of appointments scheduled for recipients enrolled in Amerigroup (AGP, 63.5 percent) and the highest number scheduled for recipients enrolled in Health Plan of Nevada (HPN, 78.1 percent).
- Of the 86 calls where an appointment could not be scheduled, 31 calls resulted in no appointment (36.0 percent) because the dental provider was no longer accepting Medicaid, and callers were unable to reach the appointment scheduling staff in 18 cases (20.9 percent) or needed to take preliminary actions before being able to schedule an appointment (16 cases, 18.6 percent).
- Overall, of the 288 calls to dental provider offices, 202 calls (70.1 percent) resulted in a dental appointment. On average, appointments with dental providers were scheduled within 11 calendar days, with wait times for an appointment ranging from same-day to 85 days.

Conclusion

Overall, the results from the SFY 2014-2015 Provider Network Access Analysis suggest that while the MCOs and FFS have developed comprehensive provider networks, opportunities for improvement exist in the implementation of these networks. In general, the MCOs and FFS have contracted with a large and varied number of providers to ensure Medicaid recipients have access to a broad array of health care services. This is evidenced by the low provider ratios of the MCOs and FFS relative to the general population. Moreover, the location of provider offices is geographically distributed to align with the Medicaid recipient population. However, the secret shopper surveys revealed substantial barriers to recipients when trying to schedule appointments. As such, while the network appears robust regarding the provider infrastructure, access to care is often affected by the ability to schedule appointments.

Future Network Studies

Based on its review of the SFY 2014-2015 Provider Network Adequacy report, the DHCFP has identified areas for improvement related to future studies. The following areas have been identified as opportunities for improving future provider network studies.

- **Expand the Provider Network Workgroup**—The DHCFP should identify potential Divisions, employees, and other key stakeholders that may contribute to the Network Analysis process.

- **Define study definitions early within the scope of work to ensure all workgroup recipients and the EQRO team recipients have the same understanding of the research question(s)**—terms that should be defined may include, but are not limited to: capacity, access, adequacy, travel time, travel distance, enrolled provider, active provider, appointment timeframes, and provider type standards.

- **Derive study methodology from workgroup priorities**—The recipients of the workgroup should be responsible for developing the research question(s) and providing the contracted EQRO vendor a scope of work for the project, which will focus the DHCFP's research to specific questions related to the MCOs' capacity and ability to provide quality services in a timely manner.

- **Evaluate and establish appropriate benchmarks**

- **Review, identify, and generate improved data sources**

Introduction

The State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) were requested to do an analysis of the adequacy of the Medicaid provider network. There are many factors that impact this analysis which are beyond the ability of the DHCFP to measure or control and therefore limit the DHCFP's ability to render conclusions regarding the adequacy of the Medicaid Network. The DHCFP will discuss these limitations and the assumptions made, in the endeavor to provide a view of the current Medicaid fee-for-service (FFS) and managed care organization (MCO) networks.

Per federal regulation, every ordering, referring, and service provider, including those who provide care only through one of Nevada's Medicaid managed care networks, must be enrolled as a provider in the Medicaid Management Information System. Though the DHCFP has processes in place to maintain the accuracy of this network, information changes daily, resulting in inaccurate provider files. Medicaid providers may also enroll with Medicaid solely for the purpose of receiving payment for emergency services rendered to Medicaid recipients; these providers may change their panel status regarding new recipients at any time. Medicaid providers may, and generally do, provide medical services to patients covered by different payers (e.g., Medicaid, Medicare, or private insurance), so the number or percent of patients they are willing to take from any one payer type is unknown. Due to the potential for daily or weekly changes in these variables, there is no way to determine if an active provider is open to seeing new Medicaid recipients, or to determine the percentage of Medicaid recipients to which their practice is willing to provide care.

Fourteen of Nevada's seventeen counties have been determined to be Health Professional Shortage Areas (HPSAs). HPSAs are designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental, or mental health providers. For recipients enrolled in one of Nevada Medicaid's MCOs, the MCO is required to assist the recipient in accessing medically necessary care. If in-state care is not available, this may include the use of an out-of-state provider.

Medicaid enrolls out-of-state providers, and this group of providers increases the access to care for Medicaid recipients. As a result, out-of-state providers have been included in the network ratio analysis. Many of these providers are geographically closer to recipients living near the Nevada border than some providers practicing within the state. These catchment area providers are subjected to the same requirements as in-state providers with regard to covered services and prior authorization requirements. Other out-of-state providers may be located farther from Nevada's border, but provide very specialized services, such as pediatric heart transplants, nursing facility services for behaviorally complex individuals, or residential treatment center services for brain injury, eating disorders, or sexual offenders.

Study Objective

The purpose of the FY 2014-2015 Provider Network Access Analysis ("network analysis") is to compare the accessibility of Nevada Medicaid's provider networks—FFS and MCO—to that of the

general public. The DHCFP requested its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), to conduct the network analysis.

The analysis evaluated three dimensions of access and availability:

- **Capacity** – provider-to-recipient ratios for Nevada's provider networks
- **Geographic Network Distribution** – time/distance analysis for applicable provider specialties and average distance (miles) to the closest provider
- **Appointment Availability** – average length of time (number of days) to see a provider for MCOs and FFS

A fourth dimension of access and availability is sometimes measured through recipient satisfaction surveys. In the fall of 2014, the Centers for Medicare and Medicaid Services (CMS) conducted a nationwide Consumer Assessment of Healthcare Providers and Systems[1] (CAHPS®) survey of adult Medicaid enrollees to obtain national and state-by-state measures of access, barriers to care, and satisfaction with care across financing and delivery models. Since the CMS CAHPS survey will include a breakout of Nevada statewide data, recipient satisfaction surveys will not be part of this analysis. CMS's CAHPS survey results will be made available to states in 2015.

Intersecting Dimensions of Access

Taken individually, the dimensions of access and availability described above are incomplete. Instead, evaluation of network adequacy should encompass all three dimensions in order to understand the impact of both network infrastructure (i.e., capacity and geographic network distribution) and the implementation and actions of that infrastructure (i.e., appointment availability).

First, HSAG assessed provider capacity to determine whether Nevada's Medicaid provider network contained a sufficient number of providers as well as a variety of specialists to ensure Medicaid members had the potential to access the health care services they need. This component is key to establishing adequate access although it is insufficient on its own to support access and availability expectations for Medicaid recipients. Insufficient providers and the variety of specialties in a network have a direct impact on recipients' access to care. Secondly, it is important that the distribution of Medicaid enrolled providers' practice location mirror that of the recipient population they serve. Even with a large network of enrolled providers, if they are not distributed proportionally relative to the recipients access to care will be adversely affected. Transportation and access to local care is critical to ensuring recipients receive the health care services they need.

Finally, once a given provider network's infrastructure has been identified, it is important to assess how well the network addresses the needs of the recipients. For example, while a sufficient number of providers may be enrolled in a network and they may be distributed proportionally relative the enrolled recipient population, individual doctors must be active and willing to accept Medicaid patients. By reviewing the ability to schedule appointments, it is possible to determine whether

[1] CAHPS refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

provider practices support or limit recipient access to care. As the results from the study are discussed, keep in mind the importance of the overall findings. While individual dimension results are important, the interaction of provider capacity and geographic distribution along with appointment availability provide the comprehensive picture of the adequacy of Nevada's Medicaid provider networks.

3. Methodology

Prior to conducting the analyses, HSAG submitted a detailed study design and methods document to the DHCFP and DHHS staff for review and approval. The DHCFP approved the following analytic methodology on March 10, 2015.

Study Population

The network analysis results presented in this report are based on comparative evaluations of both Nevada Medicaid recipients and the providers who serve them. Additionally, comparison groups, or populations, of Nevada residents and providers were also defined to evaluate network performance relative to the general population in Nevada.

Specifically, the study population included Medicaid recipients enrolled in the managed care program or with FFS as of December 1, 2014, and resided within the State of Nevada. The study population also included individual and facility-based providers who were enrolled with either of the two MCOs [i.e., Amerigroup (AGP) and Health Plan of Nevada (HPN)] or FFS[2]. In addition to the study population, two comparison groups were defined to conduct all comparative evaluations of performance. These populations included aggregated counts of all residents, by zip code, within the State of Nevada based on federal census data and active providers licensed in the State of Nevada.

Table 3-1 shows the provider categories used to report the adequacy of Nevada's provider network and includes primary care physicians, specialists, facilities, and specialty providers.

Table 3-1—Provider Categories Included in the Network Analysis	
Primary Care Physicians and Specialists	
Primary Care Providers	Neurology
PCP Extenders	OB/GYN
Allergists	Oncology/Hematology
Anesthesiologists	Orthopedic Medicine
Cardiology	Pathology
Dentists	Pediatric Mental Health Specialists
Dermatology	Pediatric Physical Health Specialists
Ear Nose and Throat	Psychiatry
Endocrinology	Pulmonary Medicine
Gastroenterology	Radiology

[2] Since the MCOs and FFS program are able to use out-of-state providers to provide services to Nevada Medicaid recipients, all providers—regardless of practice location—were included in the capacity and geographic analyses. While out-of-state providers are commonly associated with specialists, Nevada's managed care and FFS service areas include out-of-state zip codes that border Nevada. These catchment areas have been established to serve Medicaid recipients who reside in border areas where the nearest provider (specialist or non-specialist) may be in a different state.

Table 3-1—Provider Categories Included in the Network Analysis	
Primary Care Physicians and Specialists, *continued*	
General Surgery	Rehabilitation
Geriatrics[A]	Rheumatology
Infectious Disease	Urology
Maternal/Fetal Medicine	Vision
Mental Health Outpatient Services	Other Surgeries
Nephrology	
Facilities and Specialty Providers	
Ambulatory Surgery Centers	
Dialyses/ESRD Facility	
Home Health	
Hospice[A]	
Inpatient Hospital	
Intermediate Care Facilities/ID[A]	
Outpatient Hospital[B]	
Personal Care Attendants (PCA) [C]	
Psychiatric Inpatient Hospital	
Rehabilitation	
Skilled Nursing Facility	

[A] The aged and disabled population is carved out of managed care. Services typically provided to aged and disabled persons by certain provider types are not part of the managed care benefit; therefore, MCOs are not required to maintain contracts with the following provider types: Hospice, Geriatrics, and Intermediate Care Facility/ID.
[B] These facility-based categories will only be reported for FFS and the MCOs. Sufficient data is not available to distinguish the type of hospital facility for the general provider population in Nevada. Additionally, HPN staff stated that Outpatient Hospitals were categorized as Ambulatory Surgery Centers within the HPN provider data file.
[C] Analysis will be conducted on these facilities/agencies; however, they will not be reported publicly and used only for internal purposes. Since these facilities/agencies vary greatly in agency size, provider counts may not reflect the actual number individual providers available to Medicaid members. Additionally, a single facility/agency location may be noted when services are rendered statewide in the community.

For select provider categories, additional age and gender restrictions were placed on the Medicaid population related to benefit limits, specific benefit packages, or service delivery parameters. Table 3-2 identifies the provider categories and their respective restrictions.

Table 3-2—Age/Gender Restrictions of Medicaid Population for Select Provider Categories

Provider Category	Medicaid Population Restrictions
Dentists	Recipients under 21 years of age[A] as of December 1, 2014
Maternal/Fetal Medicine	Female recipients 12 years and older[A] as of December 1, 2014
OB/GYN	Female recipients 12 years and older[A] as of December 1, 2014

Table 3-2—Age/Gender Restrictions of Medicaid Population for Select Provider Categories	
Provider Category	**Medicaid Population Restrictions**
Pediatric Mental Health Specialists	Recipients under 21 years of age[A] as of December 1, 2014
Pediatric Physical Health Specialists	Recipients under 21 years of age[A] as of December 1, 2014

[A] The data used to capture the Nevada general population is obtained from the US Census Bureau, and is limited to population counts by zip code, gender, and pre-defined age-band groups (i.e., 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, … 80-84, 85+). For this study, the 0-4, 5-9, 10-14, and 15-19 age groups were used when evaluating pediatric services (i.e., dental and pediatric mental and physical health specialties). The 10-14, 15-19, …, 85+ age groups were used for evaluations related to Maternal/Fetal Medicine and OB/GYNs.

Data Collection

To complete the network analysis, HSAG obtained recipient, provider, and general population data from a number of different sources. Table 3-3 outlines the key data sources used to conduct the study by population.

Table 3-3—Data Source		
Population	**Source for Recipient Data**	**Source for Provider Data**
Nevada general population[A]	US Census Bureau, 2010 population estimates for Nevada[B]	National Plan and Provider Enumeration System (NPPES)[C], health care providers with an active National Provider Identifier (NPI) and license in the State of Nevada[D]
FFS	DHCFP data file, Medicaid beneficiaries enrolled with FFS as of December 1, 2014	DHCFP data file, Medicaid providers active as of December 1, 2014
AGP	DHCFP data file, Medicaid beneficiaries enrolled with AGP as of December 1, 2014	AGP data file, Medicaid providers active as of December 1, 2014
HPN	DHCFP data file, Medicaid beneficiaries enrolled with HPN as of December 1, 2014	HPN data file, Medicaid providers active as of December 1, 2014

[A] HSAG worked directly with the US Census Bureau to obtain the most up-to-date population data for the State of Nevada that included data by zip codes and allowed segmentation by age bands and gender, which is needed to determine appropriate capacity for certain provider types. For example, data segmentation by age (age 10 and above) and gender (female) are necessary to determine the appropriate provider to general population ratio for OB/GYNs. Although more recent population estimates were available at the time of the study, the more recent data could not be used since it did not contain the specificity required to conduct the planned analyses—i.e., age and gender stratifications by zip code. However, a comparative analysis of the 2010 census counts and the 2014 census estimates yielded less than a 5 percent difference in the reported population suggesting relative comparability between the data sources.

[B] U.S. Census Bureau, 2010 Census. *American FactFinder: Nevada – 5-digit zip code tabulation area - 860, Table P1. Retrieved on February 20, 2015, from* http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t.

[C] Centers for Medicaid and Medicare Services. (January 2015). *National Plan and Provider Enumeration System*. Monthly Data File.

[D] The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. CMS mandates reporting to the NPPES by all providers and facilities.

Data Processing

Following procurement of the recipient and provider data; HSAG cleaned, processed, and prepared the recipient and provider data for the analysis. All general population, Medicaid recipient, and provider files were standardized and geo-coded using the Quest Analytics software. During the geo-coding process, addresses with inaccurate zip codes were highlighted and corrected, where possible, by HSAG analysts to maximize the number of providers and recipients included in the study. The final Medicaid population used in the following analyses were limited to recipients (FFS, MCOs, and general population) residing within the State of Nevada while the full provider network identified by FFS and the MCOs, regardless of office location, were included in the study.[3] The DHCFP does not categorize provider types in the same way that each MCO categorizes provider types; therefore, DHCFP and HSAG developed a crosswalk for the chosen provider types and specialties across both MCOs and FFS that shows the mapping of the categorization. As a result, numbers for each selected provider type and facility may not exactly reflect the MCO's provider counts. Providers that had no specialty identified, or a specialty not matching the listed categories within the provider crosswalk, were filtered out of the analysis. Further, provider types that were not included in the full provider file submitted by MCOs were not included in the study. Although provider counts were presented and discussed with the MCOs prior to issuing the report, HPN has indicated nuances occurring from provider type categorization resulted in lower than actual counts reported for their Mental Health Outpatient, Psychiatry, and Psychiatric Inpatient Hospitals, which are shown in the following tables in Section 4 of this report: Table 4-2, Table 4-3, Table 4-7, Table 4-8, Table 4-10, and Table 4-11.See Appendix A for a crosswalk of the specific *Provider Type* and *Provider Specialty* fields used to define these provider categories across the MCOs and FFS. A separate crosswalk was used to map the primary classification and provider categories for providers listed in the NPPES data (see Appendix B).

Once the data files were cleaned and processed for inclusion in the analysis, HSAG generated the following preliminary counts of the providers and recipients for FFS, the MCOs, and the general population. A template for these results is presented in Table 3-4.

Table 3-4—Recipient and Provider Demographics

Reporting Category	General Population	Medicaid Population					
		FFS[A]		AGP[A]		HPN[A]	
Demographics							
Total Count	2,730,699	186,226		175,291		223,700	
Persons < 21 years	729,739	69,888		121,345		108,766	
Females ≥ 12	1,172,691	80,990		57,652		79,681	
Primary Care Providers		**Total**	**In-State**	**Total**	**In-State**	**Total**	**In-State**
Primary Care Physician	3,231	3,796	2,662	829	829	981	967
Physician Extenders[B]	1,857	1,635	1,264	429	429	669	663

[3] Outlier provider locations were individually evaluated to ensure they did not skew or bias the time/distance results. No cases were excluded from the analysis based on minimal impact of outliers on the analysis.

Table 3-4—Recipient and Provider Demographics							
Reporting Category	General Population	Medicaid Population					
		FFS[A]		AGP[A]		HPN[A]	
Specialists		**Total**	**In-State**	**Total**	**In-State**	**Total**	**In-State**
Allergists	43	9	6	10	10	8	8
Anesthesiologists	699	987	550	268	268	356	356
Cardiology	355	358	228	118	118	160	158
Dentists	2,403	943	885	187	186	359	356
Dermatology	129	96	45	18	18	24	24
Ear, Nose and Throat	82	108	60	19	19	37	37
Endocrinology	79	67	33	16	16	17	17
Gastroenterology	137	174	105	54	54	69	69
General Surgery	335	275	161	81	81	82	82
Geriatrics	81	24	21	N/A	N/A	N/A	N/A
Infectious Disease	62	68	44	16	16	21	21
Maternal/Fetal Medicine	35	126	71	89	89	70	70
Mental Health Outpatient Services	4,793	1,058	1,030	444	444	270	270
Nephrology	124	117	79	45	45	40	40
Neurology	64	291	148	57	57	67	67
OB/GYN	465	431	289	178	178	182	180
Oncology/Hematology	172	179	113	67	67	76	76
Orthopedic Medicine	328	305	191	66	66	69	68
Pathology	123	220	90	47	47	43	43
Pediatric Mental Health Specialist	111	40	21	12	12	18	18
Pediatric Physical Health Specialists	190	247	67	75	75	78	77
Psychiatry	428	181	148	109	109	88	88
Pulmonary Medicine	100	96	51	27	27	42	42
Radiology	410	746	326	200	200	182	177
Rehabilitation	2,585	1,267	1,192	234	234	471	469
Rheumatology	39	43	24	20	20	17	17
Urology	88	97	65	39	39	24	23
Vision	884	641	523	144	144	335	334
Other Surgeries	168	83	53	18	18	18	18
Facilities and Specialty Providers							
Ambulatory Surgical Centers	92	87	66	22	22	40	40
Dialysis/ESRD Facility	61	46	45	24	24	14	13
Home Health	484	66	64	11	11	12	12
Hospice	86	37	32	N/A	N/A	N/A	N/A
Inpatient Hospital	125	89	22	14	14	20	16
Intermediate Care Facility/ID	18	12	9	N/A	N/A	N/A	N/A
Outpatient Hospital	0	144	25	36	36	0[C]	0[C]
Personal Care Attendants (PCA)	0	107	107	1	1	3	3

Table 3-4—Recipient and Provider Demographics							
Reporting Category	General Population	Medicaid Population					
		FFS[A]		AGP[A]		HPN[A]	
Facilities and Specialty Providers, continued		**Total**	**In-State**	**Total**	**In-State**	**Total**	**In-State**
Psychiatric Inpatient Hospital	186	84	15	10	10	5	5
Rehabilitation Facility	27	16	13	2	2	5	5
Skilled Nursing Facility	85	80	51	8	8	14	14

[A] The Medicaid provider network consists of in- and out-of-state providers contracted to ensure appropriate access for Medicaid recipients. For the purposes of this study, all providers contracted with Nevada's Medicaid program were included in the analysis regardless of their location. Out-of-state providers will be enrolled and listed in provider network files even if they only provide a single service to a member. As such, out-of-state counts can appear high relative to in-state counts depending on specialty.

[B] PCP Extenders are other health care professionals practicing in the same office location (i.e., certified nurse practitioners, nurse midwife, physician assistant, or any other MCO-defined specialties that reflected a provider type 24, 74, or 77 as shown in Appendix A).

[C] HPN staff stated that Outpatient Hospitals were categorized as Ambulatory Surgery Centers within the HPN provider data file.

[N/A] The aged and disabled population is carved out of managed care. Services typically provided to aged and disabled persons by certain provider types are not part of the managed care benefit; therefore, MCOs are not required to maintain contracts with the following provider types: Hospice, Geriatrics, and Intermediate Care Facility/ID.

Prior to conducting the ratio analyses, the Medicaid recipient population was restricted to those recipients residing within the State of Nevada. However, since Medicaid recipients can receive medical services from providers outside of Nevada, all providers, regardless of office location, were included in the analysis.

Analysis

As noted earlier, the Nevada Provider Network Analysis evaluates three dimensions of the provider access and availability—i.e., provider capacity, geographic network distribution, and appointment availability. Taken together, these three analyses provide insight into the underlying network infrastructure as well its application and interaction with Nevada's Medicaid population.

Provider Capacity Analysis

In order to assess the capacity of a given provider network, HSAG compared the number of providers associated with an MCO's or FFS' provider network relative to the number of assigned recipients. This provider-to-recipient ratio (provider ratio) represents a summary statistic used to highlight the overall capacity of a plan's or program's provider network to deliver services to Medicaid recipients. Specifically, the provider ratio measures the number of providers[4] by provider type (e.g., primary care providers (PCPs), cardiologists, etc.) relative to the number of recipients. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available to render services to individuals. However, caution should be used when interpreting the results of this statistic as it does not account for key practice characteristics—i.e., panel status, acceptance of new patients, practice restrictions, etc. Instead, this analysis should be viewed as establishing a theoretical threshold for an acceptable *minimum* number of providers necessary to support a given volume of recipients.

[4] For the ratio analysis, provider counts are based on unique providers and not provider locations.

Two types of evaluations were performed based on the calculated provider ratios:

- HSAG compared the provider ratios for PCPs, PCP Extenders (i.e., certified nurse practitioner, nurse midwife, physician assistant, or any other MCO-defined specialties that reflected a provider type 24, 74, or 77 as shown in Appendix A), and dentists to verify that the MCOs are in compliance with the ratios established by the DHCFP/MCO contract.
- For provider categories where no established standards exist, Nevada's Medicaid provider ratios were presented alongside the State's general population provider ratios in order to evaluate the capacity of a Medicaid plan's/program's provider network for recipients relative to that of the general population.

In addition, HSAG compared the provider ratios for PCPs, PCPs with extender (i.e., other health care professionals practicing in the same office location), and dentists to verify that the MCOs were in compliance with the ratios established by the DHCFP/MCO contract (RFP 1988). These standards are presented in Table 3-5.[5]

Table 3-5—Access Standards for Appointment Availability	
Provider/Appointment Type	**Appointment Availability Standard**
PCP	1:1,500
PCP Extenders	1:1,800
Dental (Routine)	1;1,500

Geographic Network Distribution

The second dimension of this study evaluates the geographic distribution of providers relative to recipient populations. While the capacity analysis identified whether the network infrastructure was sufficient in both number of providers and variety of specialties, the geographic network distribution analysis ensures provider locations spread proportionally with the recipient population.

To provide a comprehensive view of geographic distribution of providers relative to recipient populations, HSAG calculated two spatial-derived metrics: (1) percentage of recipients within predefined access standards, and (2) the average distance and travel time to the nearest provider. Both analyses used software from Quest Analytics to calculate the results which took the duration of travel time or physical distance between the addresses of recipients and the addresses of their nearest providers. All results were stratified by plan/program (i.e., AGP, HPN, FFS, and the Nevada general population) according to the provider specialties and categories listed in Table 3-1. For PCPs, where geographic standards currently exist (see Table 3-6), a time/distance analysis was conducted to identify the percentage of Medicaid beneficiaries residing within the standards required by the DHCFP/MCO contract.[6]

[5] DHCFP/MCO contract standards were applied to both MCOs and FFS.
[6] DHCFP/MCO contract standards were applied to both MCOs and FFS.

Table 3-6—Access Standards for the Time/Distance Analysis	
Provider Category	**Distance-Based Access Standard**
Primary Care Providers	1 provider within 25 miles
PCP Extenders	1 provider within 25 miles

Additionally, HSAG evaluated the average distance (in miles) and travel time (in minutes) between and recipient and the closest provider for all provider and facility types listed in Table 3-1. A smaller average distance or shorter travel time[7] indicates greater accessibility to providers since individuals must travel fewer miles or minutes to access care. In general, the smaller the average distance is between recipients and providers across specialties the greater alignment in the geographic distribution of providers to the geographic distribution of recipients. When evaluating the results of these analyses, it's important to note that the reported, average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid recipients; the shorter the average drive the more similar the distribution of providers is relative to recipients.

Since detailed address data was not available for the general population, the average distance and travel time between a specific provider location and recipients was calculated using the recipients' zip code.[8] However, the average distance and travel time of the Medicaid population will be derived from the specific recipient and provider locations. In the absence of contract standards, FFS and MCO performance was compared to the general population to evaluate relative performance. All results were stratified by provider categories.

Appointment Availability

Whereas the first two evaluation dimensions assessed the MCOs and FFS provider network infrastructure (i.e., capacity and distribution), HSAG's analysis of appointment availability assesses the extent to which the network infrastructure translates to practice. To evaluate appointment availability, HSAG conducted a secret shopper telephone survey of providers' offices to evaluate the average length of time it takes for a Medicaid recipient to schedule an appointment with a Nevada-licensed provider. A secret shopper is a person employed to pose as a shopper, client, or patient in order to evaluate the quality of customer service or the validity of information (e.g., accurate prices or location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential biases introduced by knowing the identity of the surveyor.

Both contracted MCOs and the FFS program were included in the sampling process. HSAG used a two-stage random sampling approach to generate a list of sampled provider locations equally distributed across provider/appointment type (e.g., PCPs, specialists, dentists, and prenatal care providers). The sampled providers were surveyed by telephone and the information collected was

[7] Quest Analytics determines drive time based on the following parameters: 30 MPH for urban, 45 MPH for suburban, and 55 MPH for rural. Estimates do not account for time of day, traffic, or traffic control devices (i.e., stop signs, stop lights, etc.).
[8] Using QuestAnalytics software, the Nevada general population counts were distributed proportionally within the zip code based on US Census data to ensure the most accurate accounting of time and distance to providers.

used to evaluate the availability of appointments and determine whether appointment availability met the standards established by the DHCFP/MCO contract. These standards are presented in Table 3-7.[9]

Table 3-7—Access Standards for Appointment Availability	
Provider/Appointment Type	**Appointment Availability Standard**
PCP Appointments (Routine)	2 weeks (or 14 calendar days)
Specialists (Routine)	30 calendar days
Dental (Routine)	30 calendar days
Prenatal Care – First and Second Trimester	7 calendar days
Prenatal Care – Third Trimester	3 calendar days

Although appointment availability results were captured at the provider level, it is important to remember that the standards presented in Table 3-7 are specific to MCOs. This means that the MCOs are held accountable for ensuring recipients have access to a provider within the required time frames. In many cases, when recipients are unable to secure an appointment with a provider, they work with the MCO to coordinate the required appointment. Additionally, the standard is independent of a specific recipients' choice of providers. In other words, the standard informs MCOs that, upon request, they must be able to schedule a recipient with any provider's office within 14 calendar days; they are not required to schedule them with a specific provider's office.

The eligible population consisted of Medicaid providers enrolled with the MCOs or FFS and practicing within the State of Nevada. Based on the eligible population, HSAG generated a random sample of 384 providers stratified, and equally distributed (i.e., 96 providers per strata), into the following four provider categories (i.e., PCPs, Specialists, Dentists, and Prenatal Care).[10,11] When more than one location exists for a sampled provider, HSAG randomly selected one location. This sampling strategy ensured a maximum margin of error of +/- 5 percent and 95 percent confidence level at the plan level, and a maximum margin of error of +/- 10 percent (with 95 percent confidence level) at the provider/appointment type level. An additional 25 percent oversample (24 cases per strata, or 96 cases total) were sampled to account for invalid or incomplete provider contact information; resulting in a final sample size of 1,440 cases across all plans and program.

Telephone Survey of Providers' Offices

HSAG staff called providers' offices listed in the sample to determine the length of time (in days) required to obtain an appointment with each selected provider. HSAG staff made up to two phone

[9] DHCFP/MCO contract standards were applied to both MCOs and FFS.

[10] The SPECIALISTS strata included all providers outlined in Table 1 excluding PCPs, PCP extenders, OB/GYNs, dentists, and facilities. Please note that outpatient mental health providers were included in the SPECIALISTS category. Facilities; however, were excluded from the appointment availability analyses.

[11] Due to differing appointment availability standards for prenatal care providers based on a recipient's trimester of pregnancy, the prenatal care provider sample (96 cases) was further sub-divided to capture both populations (48 cases per sub-strata).

calls to each selected provider office during standard operating hours.[12] If a provider office was unreachable, the case was replaced with a case from the oversample. If the secret shopper reached an answering service or voicemail, a second attempt was made to schedule an appointment during confirmed operational hours. If no contact was ever made, the telephone script was noted as complete and the provider was noted as being "unavailable." Appendix C contains the script HSAG used when calling the offices to verify providers' information and clinical scenarios used when scheduling appointments with specialists.

[12] Samples were drawn independently from the FFS and MCO provider populations. As such, overlap in sampled providers did occur within the smaller specialist provider categories—i.e., dentists and prenatal care physicians. If a physician was selected for more than one sample (e.g., HPN and AGP), the provider was contacted separately for each of the MCOs.

Provider Capacity Analysis

The provider-to-recipient ratio (provider ratio) highlights the overall capacity of a plan's or program's provider network to deliver services to Medicaid recipients. Specifically, the provider ratio measures the number of providers[13] by provider type (e.g., primary care providers (PCPs), cardiologists, etc.) relative to the number of recipients. A lower provider ratio suggests greater network access since a larger pool of providers is available to render services to individuals.

The results presented in the following tables highlight the provider ratios by PCPs, specialists, and facilities and specialist providers for the MCOs, FFS, and the general population. Table 4-1 shows the results for primary care providers. Unlike most provider types, a Nevada standard exists for PCPs and PCP extenders.

Table 4-1—PCP Provider Ratios for Nevada's General and Medicaid Populations

Provider Category (Standard)	Provider Ratios			
	General Population	FFS	AGP	HPN
Primary Care Providers (1:1,500)	1:845	1:49	1:211	1:228
PCP Extenders (1:1,800)	1:1,470	1:114	1:409	1:334

Overall, the Medicaid provider ratios for PCPs and PCP Extenders across FFS, AGP, and HPN were substantially better than the ratio standards set forth in the Medicaid MCO contract (i.e., 1:1,500 and 1:1,800, respectively). Additionally, the provider ratios for FFS, AGP, and HPN were better than the provider ratio reported for the general population in Nevada. These results suggest that an adequate network of primary care physicians is available to Medicaid recipients across the FFS and managed care Medicaid programs. Specifically, the PCP provider ratios for FFS, AGP, and HPN were 1:49, 1:211, and 1:228, respectively, compared to the general population provider ratio of 1:845, which also exceeds the established standard. Similarly, PCP Extender provider ratios were substantially better than the PCP Extender standard (i.e., 1:1,800) for all comparison groups: 1:1,470 for the Nevada general population, 1:114 for FFS, 1:409 for AGP, and 1:334 for HPN.

Table 4-2 shows the results for specialists.

Table 4-2—Specialist Provider Ratios for Nevada's General and Medicaid Populations

Provider Category (Standard)	Provider Ratios			
	General Population	FFS	AGP	HPN
Allergists	1:63,505	1:20,692	1:17,529	1:27,963
Anesthesiologists	1:3,907	1:189	1:654	1:628

[13] For the ratio analysis, provider counts are based on unique providers and not provider locations.

Table 4-2—Specialist Provider Ratios for Nevada's General and Medicaid Populations				
	Provider Ratios			
Provider Category (Standard)	General Population	FFS	AGP	HPN
Cardiology	1:7,692	1:520	1:1,486	1:1,398
Dentists (1:1,500)[A, C]	1:304	1:74	1:649	1:303
Dermatology	1:21,168	1:1,940	1:9,738	1:9,321
Ear, Nose, and Throat	1:33,301	1:1,724	1:9,226	1:6,046
Endocrinology	1:34,566	1:2,779	1:10,956	1:13,159
Gastroenterology	1:19,932	1:1,070	1:3,246	1:3,242
General Surgery	1:8,151	1:677	1:2,164	1:2,728
Geriatrics	1:33,712	1:7,759	N/A	N/A
Infectious Disease	1:44,044	1:2,739	1:10,956	1:10,652
Maternal/Fetal Medicine[B, C]	1:33,505	1:643	1:648	1:1,138
Mental Health Outpatient Services	1:570	1:176	1:395	1:829
Nephrology	1:22,022	1:1,592	1:3,895	1:5,593
Neurology	1:42,667	1:640	1:3,075	1:3,339
OB/GYN[B, C]	1:2,522	1:188	1:324	1:438
Oncology/Hematology	1:15,876	1:1,040	1:2,616	1:2,943
Orthopedic Medicine	1:8,325	1:611	1:2,656	1:3,242
Pathology	1:22,201	1:846	1:3,730	1:5,202
Pediatric Mental Health Specialists[A, C]	1:6,574	1:1,747	1:10,112	1:6,043
Pediatric Physical Health Specialists[A, C]	1:3,841	1:283	1:1,618	1:1,394
Psychiatry	1:6,380	1:1,029	1:1,608	1:2,542
Pulmonary Medicine	1:27,307	1:1,940	1:6,492	1:5,326
Radiology	1:6,660	1:250	1:876	1:1,229
Rehabilitation	1:1,056	1:147	1:749	1:475
Rheumatology	1:70,018	1:4,331	1:8,765	1:13,159
Urology	1:31,031	1:1,920	1:4,495	1:9,321
Vision	1:3,089	1:291	1:1,217	1:668
Other Surgeries	1:16,254	1:2,244	1:9,738	1:12,428

[A] The ratios for dentists, pediatric mental health specialists, and pediatric physical health specialists were calculated using only recipients who were younger than 21 years of age as of December 31, 2014.

[B] The ratios for the Maternal/Fetal Medicine and OB/GYN categories were calculated using only recipients who were 12 years old, or older as of December 31, 2014.

[C] The recipient data used to capture the Nevada general population was obtained from the US Census Bureau, and is limited to population counts by zip code, gender, and pre-defined age-band groups (i.e., 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, … 80-84, 85+). For this study, the 0-4, 5-9, 10-14, and 15-19 age groups were used when evaluating pediatric services (i.e., dental, and pediatric mental and physical health specialties). The 10-14, 15-19, …, 85+ age groups were used for evaluations related to Maternal/Fetal Medicine and OB/GYNs.

[N/A] The aged and disabled population is carved out of managed care. Services typically provided to aged and disabled persons by certain provider types are not part of the managed care benefit; therefore, MCOs are not required to maintain contracts with the following provider types: Hospice, Geriatrics, and Intermediate Care Facility/ID.

[NOTE:] See the Data Processing section in Section 3. Methodology for additional information regarding nuances associated with the provider data used in this analysis.

Overall, the Medicaid provider ratios for Dentists across FFS, AGP, and HPN exceeded the ratio standards set forth by the DHCFP/MCO contract (i.e., 1:1,500). Additionally, the provider ratio for FFS was much lower than the provider ratios reported for Nevada's general population, AGP, and HPN. These results suggest an adequate network of dentists is available to Medicaid recipients, especially for those in the FFS program. In addition, while the provider ratio for AGP (1:649) met the contract standard, it was higher than that reported for the general population (1:304).

For the other provider categories, the ratios for FFS, AGP, and HPN were generally lower than the provider ratios reported for the general population except for two provider categories—i.e., pediatric mental health specialist for AGP and mental health outpatient services for HPN. In every other case, the results indicate a diversified specialist network is available to Medicaid recipients when compared to the general population. For the two applicable provider groups with provider ratios greater than the general population provider ratios, DHCFP should work the MCOs to determine if additional providers in these areas are needed to address the needs of the population.

For the majority of the specialist provider categories, the provider ratios for FFS were lower than the provider ratios reported for AGP and HPN. This finding is somewhat related to the fact that while recipient population counts are similar across AGP, HPN, and FFS, there was considerable variation in the number of providers. In most cases, the number of providers reported in the FFS network exceeded the number of providers available to either of the MCOs. Since managed care providers are required to enroll with FFS even though those providers may not see FFS recipients, the FFS provider network includes many of the contracted MCO providers in addition to providers enrolled solely with the FFS program. However, each MCO's provider network only includes those providers that are contracted with the respective MCO.

Table 4-3 shows the results for facilities and specialist providers.

Table 4-3—Facility and Specialty Provider Ratios for Nevada's General and Medicaid Populations

Provider Category[A] (Standard)	Provider Ratios			
	General Population	FFS	AGP	HPN
Ambulatory Surgical Centers	1:29,682	1:2,141	1:7,968	1:5,593
Dialysis/ESRD Facility	1:44,766	1:4,048	1:7,304	1:15,979
Home Health	1:5,642	1:2,822	1:15,936	1:18,642
Hospice	1:31,752	1:5,033	N/A	N/A
Inpatient Hospital	1:21,846	1:2,092	1:12,521	1:11,185
Intermediate Care Facility/ID	1:151,706	1:15,519	N/A	N/A
Outpatient Hospital	—	1:1,293	1:4,869	—[B]
Personal Care Attendants (PCA)	—	1:1,740	1:175,291	1:74,567
Psychiatric Inpatient Hospital	1:14,681	1:2,217	1:17,529	1:44,740

Table 4-3—Facility and Specialty Provider Ratios for Nevada's General and Medicaid Populations				
	Provider Ratios			
Provider Category[A] (Standard)	General Population	FFS	AGP	HPN
Rehabilitation Facility	1:101,137	1:11,639	1:87,646	1:44,740
Skilled Nursing Facility	1:32,126	1:2,328	1:21,911	1:15,979

— Based on the provider data submitted to HSAG for this study, no providers met the criteria for these provider categories.

[A] Some services provided by the Facility and Specialty providers may be more applicable to the Nevada general population and FFS population than the Medicaid managed care program.

[B] HPN staff stated that Outpatient Hospitals were categorized as Ambulatory Surgery Centers within the HPN provider data file.

[N/A] The aged and disabled population is carved out of managed care. Services typically provided to aged and disabled persons by certain provider types are not part of the managed care benefit; therefore, MCOs are not required to maintain contracts with the following provider types: Hospice, Geriatrics, and Intermediate Care Facility/ID.

[NOTE:] See the Data Processing section in Section 3. Methodology for additional information regarding nuances associated with the provider data used in this analysis.

As with earlier provider categories, the facility and specialty provider ratios for FFS, AGP, and HPN were lower than the respective provider ratios for the general population. There were only four instances where the MCO ratios exceeded the general population provider ratios—i.e., home health and psychiatric inpatient hospitals for AGP; and home health and psychiatric inpatient hospitals for HPN. In all but one case (AGP's psychiatric inpatient hospital ratio), there were more than 10,000 extra recipients per provider. For the provider groups with provider ratios higher than the general population provider ratios, DHCFP should work the MCOs to determine, where appropriate, if additional providers in these areas are needed to address the needs of the population.

Based on the provider data supplied by the MCOs, several provider categories were not reported by AGP and HPN. Specifically, since the aged and disabled population is carved out of managed care, MCOs are not required to maintain contracts with the following provider types: hospice, geriatrics, and intermediate care facility/ID. For HPN, no providers were identified that met the criteria for outpatient hospital providers; however, subsequent discussions with HPN suggested that outpatient hospital providers where documented as ambulatory surgery centers in its provider data.

Additionally, based on the provider data extracted from the NPPES, several provider categories were also not reported for the general population—i.e., outpatient hospitals and personal care attendants (PCA). As a result, the provider ratios reported for FFS, AGP, and HPN could not be compared to the general population. However, HSAG noted that both AGP's and HPN's provider ratios for PCAs (1:175,291 and 1:74,567, respectively) were substantially higher than the provider ratios reported for the FFS population (1:1,740).

Geographic Network Distribution Analysis

Distance-based Access

The distance-based access standard measure evaluated the percentage of recipients residing within a distance-based access standard; it represents a performance metric used to highlight the geographic distribution of a plan's or program's provider population relative to its Medicaid recipients. A

higher percentage suggests greater network access since a larger proportion of recipients reside within a given distance standard relative to the nearest provider. This evaluation was performed for two provider categories—i.e., Primary Care Providers and PCP Extenders. Table 4-4 shows the distance-based access standards outlined in the DHCFP/MCO contract.

Table 4-4—Access Standards for the Time/Distance Analysis	
Provider Category	**Distance-based Access Standard**
Primary Care Providers	1 provider within 25 miles
PCP Extenders	1 provider within 25 miles

HSAG used software from Quest Analytics to calculate the percentage of recipients that met the distance-based access standards. Specifically, the physical distance between the addresses of recipients and the addresses of their nearest providers[14] by provider type was calculated; the number and percent recipients that resided within the pre-defined distance standard were then determined. Table 4-5 shows the results of the analysis by geographic area.

Table 4-5—Percent of Recipients Residing within Distance-based Access Standards								
	Urban/Suburban				Rural			
Provider Category	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
PCP	100%	100%	>99.9%	>99.9%	91.9%	92.9%	99.5%	99.6%
PCP Extenders	100%	>99.9%	>99.9%	>99.9%	92.5%	88.0%	99.5%	99.6%

Overall, more than 99.9 percent of AGP, HPN, and FFS recipients in the urban and suburban areas resided within the distance-based access standards for PCPs and PCP Extenders (i.e., 25 miles) with 100 percent of the general population and FFS (PCP category only) within 25 miles of the nearest provider. At least 99.5 percent of recipients enrolled with the MCOs were located within 25 miles of the nearest provider regardless of whether it was an urban/suburban or rural area.

In rural areas, the percentage of recipients residing within the distance-based access standard for PCPs remained high for AGP and HPN (99.5 percent and 99.6 percent, respectively) while the general population and FFS percentages were somewhat lower (91.9 percent and 92.9 percent, respectively). A similar trend was noted for PCP Extenders where the percentage of recipients residing within the distance-based access standard for PCP Extenders was high for AGP and HPN (99.5 percent and 99.6 percent, respectively). The general population and FFS percentages were somewhat lower (92.5 percent and 88.0 percent, respectively) for PCP Extenders in the rural areas.

[14] For the time/distance analyses, provider counts are based on unique provider locations.

Time/Distance Analysis

The time/distance analyses evaluated the average driving time[15] and distance between recipients and the nearest provider[16] using software from Quest Analytics. To provide a comprehensive view of recipients' access to providers, HSAG evaluated two components for each category: (1) the average driving time to the nearest provider, and (2) the average driving distance to the nearest provider. Lower average driving times or distances suggest a more adequate network. A smaller average distance or shorter travel time[17] indicates greater accessibility to providers since individuals must travel fewer miles or minutes to access care. In general, the smaller the average distance is between recipients and providers across specialties the greater alignment in the geographic distribution of providers to the geographic distribution of recipients. When evaluating the results of these analyses, it's important to note that the reported, average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid recipients; the shorter the average drive the more similar the distribution of providers is relative to recipients.

Table 4-6 through Table 4-8 highlight the average driving time between Medicaid recipients and the nearest provider by geographic location. A lower average driving time suggests greater accessibility to providers since individuals must travel fewer minutes to access care. The results were derived from the estimated drive time between recipient and provider locations relative to expected driving speeds associated with the geographic terrain—i.e., urban, suburban, and rural geographic areas.

Table 4-6—Average Drive Time (in minutes) to the Nearest PCP Provider by Geographic Classification

Provider Category	Urban/Suburban				Rural			
	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
PCPs	1.9	1.9	2.2	2.3	7.0	7.5	3.0	3.7
PCP Extenders	2.0	2.4	2.7	2.8	8.0	11.2	3.2	3.9

Table 4-6 shows the average drive time to the nearest PCP or PCP Extender was approximately 10 minutes or less across all populations with average drive times ranging from 1.9 minutes to the nearest PCP for FFS and the general population (urban/suburban locations) to 11.2 minutes to the nearest PCP Extender for FFS (rural locations). Moreover, the average drive time for Medicaid recipients was 3.4 minutes for PCPs and 4.4 minutes for PCP Extenders regardless of geographic location compared to the general population (i.e., 4.5 minutes and 5.0 minutes, respectively).

[15] Quest Analytics determines drive time based on the following parameters: 30 MPH for urban, 45 MPH for suburban, and 55 MPH for rural.

[16] Due to the impact of out-of-state providers on average driving times and distance, the time/distance analyses were restricted to providers located in states contiguous with Nevada.

[17] Quest Analytics determines drive time based on the following parameters: 30 MPH for urban, 45 MPH for suburban, and 55 MPH for rural. Estimates do not account for time of day, traffic, or traffic control devices (i.e., stop signs, stop lights, etc.).

The average time to the nearest primary care provider (both PCPs and PCP Extenders) in urban/suburban locations (2.3 minutes) is shorter than the average time to the nearest primary care provider in a rural location (5.9 minutes).

Table 4-7 shows the average drive time results for specialists.

Table 4-7—Average Drive Time (in minutes) to the Nearest Specialist by Geographic Classification

Provider Category	Urban/Suburban				Rural			
	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
Allergists	13.4	34.6	7.0	7.4	72.0	110.1	6.7	10.0
Anesthesiologists	4.9	7.4	6.2	5.9	19.1	35.4	6.7	4.8
Cardiology	5.9	9.2	5.7	5.5	22.2	40.3	5.3	5.6
Dentists[A, C]	2.0	4.3	2.6	2.2	9.0	18.9	4.0	2.8
Dermatology	11.4	19.0	8.7	8.1	64.7	53.6	7.5	6.6
Ear, Nose and Throat	8.9	14.1	9.0	8.3	43.4	52.7	9.5	7.4
Endocrinology	12.4	26.5	8.7	7.0	68.5	89	9.2	5.9
Gastroenterology	8.9	12.2	6.8	6.4	45.1	57.9	8.5	7.2
General Surgery	5.5	8.9	7.9	8.4	18.7	33.0	5.2	7.8
Geriatrics	10.1	26.0	N/A	N/A	58.4	86.9	N/A	N/A
Infectious Disease	14.2	28.7	10.6	7.9	78.6	99.9	11.5	8.0
Maternal/Fetal Medicine[B, C]	15.8	24.4	4.6	8.4	48.0	84.8	4.5	8.0
Mental Health Outpatient Services	1.2	3.0	4.0	4.7	7.7	11.9	5.0	5.1
Nephrology	13.9	21.1	5.9	7.3	78.5	90.3	5.9	8.2
Neurology	14.1	17.8	5.9	7.6	83.1	61.4	7.7	7.0
OB/GYN[B, C]	5.1	5.7	5.5	4.8	24.2	44.8	4.9	5.7
Oncology/Hematology	11.8	22.6	6.3	6.7	73.6	83.8	6.2	5.4
Orthopedic Medicine	5.4	8.4	5.7	7.3	17.6	46.9	5.1	8.9
Pathology	12.3	17.8	9.9	16.0	49.3	58.4	8.7	17.6
Pediatric Mental Health Specialist[A, C]	11.0	34.1	15.1	10.4	76.2	106.8	19.1	8.4
Pediatric Physical Health Specialists[A, C]	9.6	39.1	6.8	5.6	44.2	101.6	8.0	7.1
Psychiatry	5.7	10	5.1	5.1	27.1	40.8	5.2	7.0
Pulmonary Medicine	12.8	18.9	7.0	7.3	76.7	68.3	6.8	6.1
Radiology	5.9	8.4	4.8	5.1	25.8	20.1	5.3	4.7
Rehabilitation	1.7	3.1	4.0	3.3	10.4	14.8	3.8	4.0
Rheumatology	11.9	24.3	6.7	10.8	56.0	98.1	6.2	11.3
Urology	7.7	11.7	6.9	10.0	37.7	45.9	7.6	7.9

Table 4-7—Average Drive Time (in minutes) to the Nearest Specialist by Geographic Classification								
	Urban/Suburban				Rural			
Provider Category	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
Vision	3.0	4.6	3.7	3.0	14.6	15.4	4.8	3.0
Other Surgery	9.0	23.5	9.6	9.8	44.9	86.6	11.8	6.7

— Based on the provider data submitted to HSAG for this study, no providers met the criteria for these provider categories.
[A] The average drive time for dentists, pediatric mental health specialists, and pediatric physical health specialists were calculated using only recipients who were younger than 21 years of age as of December 31, 2014.
[B] The average drive time for the Maternal/Fetal Medicine and OB/GYN categories were calculated using only female recipients who were 12 years old, or older as of December 31, 2014.
[C] The recipient data used to capture the Nevada general population was obtained from the US Census Bureau, and is limited to population counts by zip code, gender, and pre-defined age-band groups (i.e., 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, … 80-84, 85+). For this study, the 0-4, 5-9, 10-14, and 15-19 age groups were used when evaluating pediatric services (i.e., dental, and pediatric mental and physical
[N/A] The aged and disabled population is carved out of managed care. Services typically provided to aged and disabled persons by certain provider types are not part of the managed care benefit; therefore, MCOs are not required to maintain contracts with the following provider types: Hospice, Geriatrics, and Intermediate Care Facility/ID.
[NOTE:] See the Data Processing section in Section 3. Methodology for additional information regarding nuances associated with the provider data used in this analysis.

The average drive time to a specialist varied considerably across provider categories with average time to the nearest specialist ranging from 5.3 minutes (Mental Health Outpatient Services) to 45.4 minutes (Geriatrics). However, some of these differences are attributable to the impact of geographic location. The average time to a specialty provider in an urban/suburban setting was 10.1 minutes compared to 31.0 minutes to a specialty provider in a rural area. Moreover, on a whole, Medicaid recipients experienced a shorter drive time across all specialty providers (18.8 minutes on average) compared to the general population (26.7 minutes, on average).

Four specialty providers exhibited consistently low drive times regardless of geographic location and program: Dentists (5.7 minutes), Mental Health Outpatient Services (5.3 minutes), Rehabilitation providers (5.6 minutes), and Vision services (6.5 minutes).

Table 4-8 shows the results for facilities and specialist providers.

Table 4-8—Average Drive Time (in minutes) to the Nearest Facility or Specialist Provider by Geographic Classification								
	Urban/Suburban				Rural			
Provider Category[A]	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
Ambulatory Surgical Centers	6.6	7.7	7.4	5.5	41.1	28.2	10.0	6.2
Dialysis/ESRD Facility	6.6	8.3	6.5	8.0	19.2	28.7	5.2	8.6
Home Health	3.2	20.7	9.4	11.1	12.2	73.9	13.3	7.2
Hospice	11.0	19.1	N/A	N/A	62.9	71.2	N/A	N/A
Inpatient Hospital	6.2	13.7	7.7	7.3	14.5	30.5	8.6	6.4
Intermediate Care	17	29	N/A	N/A	89.8	102.8	N/A	N/A

Table 4-8—Average Drive Time (in minutes) to the Nearest Facility or Specialist Provider by Geographic Classification								
	Urban/Suburban				Rural			
Provider Category[A]	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
Facility/ID								
Outpatient Hospital	—	12.8	6.0	—[B]	—	30.2	7.9	—[B]
Personal Care Attendants (PCA)	—	N/A	N/A	N/A	—	N/A	N/A	N/A
Psychiatric Inpatient Hospital	5.8	27.3	10.5	10.2	32	89.1	11.6	9.0
Rehabilitation Facility	14.2	24.3	121.3	85.6	66	88.7	50.1	34.1
Skilled Nursing Facility	5.9	7.7	9.4	7.4	17.7	17.8	13.9	6.5

— Based on the provider data submitted to HSAG for this study, no providers met the criteria for these provider categories.
[A] Some services provided by the Facility and Specialty providers may be more applicable to the Nevada general population and FFS population than the Medicaid managed care program.
[B] HPN staff stated that Outpatient Hospitals were categorized as Ambulatory Surgery Centers within the HPN provider data file.
[N/A] The aged and disabled population is carved out of managed care. Services typically provided to aged and disabled persons by certain provider types are not part of the managed care benefit; therefore, MCOs are not required to maintain contracts with the following provider types: Hospice, Geriatrics, and Intermediate Care Facility/ID. Additionally, since PCAs are agency-based providers who render health care services at patient locations, distance and time metrics are not appropriate for this provider category.
[NOTE:] See the Data Processing section in Section 3. Methodology for additional information regarding nuances associated with the provider data used in this analysis.

In general, there was a notable difference in the average drive time to a facility between Medicaid recipients and the general population (32.7 minutes and 22.7 minutes, respectively). There were also notable differences in the drive times to facilities in rural (40.8 minutes) and urban/suburban locations (22.4 minutes). On average, skilled nursing facilities (10.8 minutes), ESRD facilities (11.4 minutes), and inpatient hospitals (11.9 minutes), followed by ambulatory surgical centers (14.1 minutes) and outpatient hospitals (14.2 minutes) required the shortest travel times compared to intermediate care facilities/ID (59.7 minutes) and rehabilitation facilities (60.5 minutes).

Overall, differences in travel times between the general population, FFS, and the MCOs were smaller in urban/suburban locations compared to rural locations where the general population and FFS had longer drive times than the MCOs. This finding is likely the result of the larger proportion of rural recipients comprising these groups.

Table 4-9 through Table 4-11 highlight the average driving distance between Medicaid recipients and the nearest provider by geographic location. A lower average driving distance suggests greater accessibility to providers since individuals must travel a smaller distance to access care. The results were derived from the estimated number of drivable miles between recipient and provider locations.

Table 4-9—Average Distance (in miles) to the Nearest PCP by Geographic Classification								
	Urban/Suburban				Rural			
Provider Category	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
Primary Care Providers								
Primary Care	1.0	1.1	1.1	1.2	6.2	6.7	2.3	2.7

Table 4-9—Average Distance (in miles) to the Nearest PCP by Geographic Classification								
	Urban/Suburban				Rural			
Provider Category	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
Physician								
PCP Extenders	1.1	1.4	1.4	1.5	7.1	10.1	2.5	2.9

The average distance (in miles) to the nearest PCP or PCP Extender was approximately 10 miles or less across all populations, with the average distance ranging from about 1.0 mile for the nearest PCP for the general population (urban/suburban locations) to 10.1 minutes to the nearest PCP Extender for FFS (rural locations). All programs exhibited driving distances in urban/suburban locations of less than 2 miles. Moreover, the average distance driven by Medicaid recipients was 2.5 miles for PCPs and 3.3 miles for PCP Extenders regardless of geographic location compared to the general population (i.e., 3.6 miles and 4.1 miles, respectively).

The average distance to the nearest primary care provider (both PCPs and PCP Extenders) in urban/suburban locations (1.2 miles) is shorter than the average distance to the nearest primary care provider in a rural location (5.1 miles).

Table 4-10 shows the average distance results, in miles, for specialists.

Table 4-10—Average Distance (in miles) to the Nearest Specialist by Geographic Classification								
	Urban/Suburban				Rural			
Provider Category	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
Allergists	8.2	20.3	3.6	3.8	55.9	78.6	4.8	7.1
Anesthesiologists	2.8	4.5	3.2	3.0	16.1	28.9	4.9	3.6
Cardiology	3.3	5.5	2.9	2.8	18.7	33.3	4.0	4.2
Dentists[A, C]	1.1	2.8	1.3	1.2	8.0	16.3	3.2	2.1
Dermatology	7.1	12.5	4.5	4.1	52.6	42.7	5.5	4.7
Ear, Nose and Throat	5.0	8.6	4.5	4.2	35.2	43.2	6.7	5.2
Endocrinology	8.0	15.7	4.5	3.6	57.1	66.1	7.1	4.4
Gastroenterology	5.1	7.5	3.5	3.3	36.4	47.3	6.2	5.3
General Surgery	3.1	5.2	4.0	4.3	15.8	28.5	3.8	5.7
Geriatrics	6.4	16.6	N/A	N/A	48.9	69.0	N/A	N/A
Infectious Disease	9.1	16.9	5.3	4.0	65.2	72.1	8.1	5.6
Maternal/Fetal Medicine[B, C]	9.3	14.6	2.3	4.3	40.0	64.2	3.3	5.8
Mental Health Outpatient Services	0.7	1.8	2.1	2.4	6.8	10.3	3.8	3.8
Nephrology	8.2	13.1	3.0	3.8	58.4	65.0	4.4	6.0
Neurology	8.7	11.5	3.0	3.9	63.9	47.9	5.4	5.0
OB/GYN[B, C]	3.0	3.3	2.8	2.5	20.2	35.6	3.6	4.2
Oncology/Hematology	7.2	14.0	3.2	3.5	57.5	64.6	4.6	4.0
Orthopedic Medicine	3.1	5.0	2.9	3.7	15.0	36.5	3.9	6.2

Table 4-10—Average Distance (in miles) to the Nearest Specialist by Geographic Classification								
	Urban/Suburban				Rural			
Provider Category	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
Pathology	6.8	10.4	5.1	8.1	37.8	47.4	6.3	12.3
Pediatric Mental Health Specialist[A, C]	7.1	20.4	7.6	5.2	61.4	74.8	13.4	5.9
Pediatric Physical Health Specialists[A, C]	5.3	23.1	3.5	2.8	35.2	74.3	5.9	5.0
Psychiatry	3.5	6.6	2.6	2.6	23.4	34.1	3.8	5.1
Pulmonary Medicine	8.0	12.0	3.6	3.8	61.0	53.6	5.2	4.6
Radiology	3.4	5.1	2.4	2.7	21.1	16.8	3.9	3.6
Rehabilitation	1.0	1.8	2.0	1.7	9.2	12.8	3.0	3.0
Rheumatology	7.1	14.5	3.4	5.5	43.5	69.5	4.4	8.0
Urology	4.2	7.0	3.5	5.2	31.3	38.5	5.6	5.9
Vision	1.8	3.0	1.9	1.6	12.6	13.4	3.6	2.3
Other Surgery	5.2	15.1	4.8	5.0	36.5	68.9	8.3	5.1

— Based on the provider data submitted to HSAG for this study, no providers met the criteria for these provider categories.

[A] The average drive time for dentists, pediatric mental health specialists, and pediatric physical health specialists were calculated using only recipients who were younger than 21 years of age as of December 31, 2014.

[B] The average drive time for the Maternal/Fetal Medicine and OB/GYN categories were calculated using only female recipients who were 12 years old, or older as of December 31, 2014.

[C] The recipient data used to capture the Nevada general population was obtained from the US Census Bureau, and is limited to population counts by zip code, gender, and pre-defined age-band groups (i.e., 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, … 80-84, 85+). For this study, the 0-4, 5-9, 10-14, and 15-19 age groups were used when evaluating pediatric services (i.e., dental, and pediatric mental and physical health specialties). The 10-14, 15-19… 85+ age groups were used for evaluations related to Maternal/Fetal Medicine and OB/GYNs.

[N/A] The aged and disabled population is carved out of managed care. Services typically provided to aged and disabled persons by certain provider types are not part of the managed care benefit; therefore, MCOs are not required to maintain contracts with the following provider types: Hospice, Geriatrics, and Intermediate Care Facility/ID.

[NOTE:] See the Data Processing section in Section 3. Methodology for additional information regarding nuances associated with the provider data used in this analysis.

Similar to driving time, the average distance to the nearest specialist varied considerably across provider category with the average distance ranging from 4.0 miles (Mental Health Outpatient Services) to 35.2 miles (Geriatrics). However, some of these differences are attributable to the impact of geographic location. The average time to a specialty provider in an urban/suburban setting was 5.8 miles compared to 24.2 miles to a specialty provider in a rural area. Moreover, on a whole, Medicaid recipients experienced a shorter drive time across all specialty providers (13.3 miles on average) compared to the general population (20.6 miles, on average).

Four specialty providers exhibited consistently low average driving distances regardless of geographic location and program: dentists (4.5 miles), Mental Health Outpatient Services (4.0 miles), Rehabilitation providers (4.3 miles), and Vision services (5.0 miles).

Table 4-11 shows the average distance results for facilities and specialist providers.

Table 4-11—Average Distance (in miles) to the Nearest Facility and Specialist Provider by Geographic Classification								
	Urban/Suburban				Rural			
Provider Category[A]	General Population	FFS	AGP	HPN	General Population	FFS	AGP	HPN
Ambulatory Surgical Centers	3.9	4.5	3.8	2.8	34.1	23.9	7.1	4.4
Dialysis/ESRD Facility	3.8	5.1	3.3	4.1	16.3	24.4	4.0	6.1
Home Health	1.8	14.1	4.8	5.6	10.5	62.7	9.3	5.1
Hospice	6.7	12.5	N/A	N/A	52.7	59.4	N/A	N/A
Inpatient Hospital	3.5	8.0	3.9	3.7	12.3	25.4	6.4	4.6
Intermediate Care Facility/ID	9.6	16.8	N/A	N/A	62.9	72.0	N/A	N/A
Outpatient Hospital	—	7.6	3.1	—[B]	—	25.3	5.8	—[B]
Personal Care Attendants (PCA)	—	N/A	N/A	N/A	—	N/A	N/A	N/A
Psychiatric Inpatient Hospital	3.4	16.2	5.3	5.4	26.7	65.6	8.1	6.4
Rehabilitation Facility	8.9	14.6	61.1	59.1	55.6	67.6	35.1	30.6
Skilled Nursing Facility	3.3	4.6	4.8	3.7	14.9	15.1	9.8	4.6

— Based on the provider data submitted to HSAG for this study, no providers met the criteria for these provider categories.

[A] Some services provided by the Facility and Specialty providers may be more applicable to the Nevada general population and FFS population than the Medicaid managed care program.

[B] HPN staff stated that Outpatient Hospitals were categorized as Ambulatory Surgery Centers within the HPN provider data file.

[N/A] The aged and disabled population is carved out of managed care. Services typically provided to aged and disabled persons by certain provider types are not part of the managed care benefit; therefore, MCOs are not required to maintain contracts with the following provider types: Hospice, Geriatrics, and Intermediate Care Facility/ID. Additionally, since PCAs are agency-based providers who render health care services at patient locations, distance and time metrics are not appropriate for this provider category.

[NOTE:] See the Data Processing section in Section 3. Methodology for additional information regarding nuances associated with the provider data used in this analysis.

Unlike drive time, there was a small difference in the average distance to a facility between Medicaid recipients and the general population (22.4 miles and 20.6 miles, respectively). However, the larger differences in the distance to facilities were related to geographic location where rural (31.4 miles) distances were double, on average, to those in urban/suburban locations (12.5 miles). On average, skilled nursing facilities (7.6 miles), ESRD facilities (8.4 miles), and inpatient hospitals (8.5 miles), followed by ambulatory surgical centers (10.6 miles), and outpatient hospitals (10.5 miles) were the closest facilities to recipients compared to intermediate care facilities/ID (40.3 miles) and rehabilitation facilities (41.6 miles).

Overall, differences in travel distance between the general population, FFS, and the MCOs were smaller in urban/suburban locations compared to rural locations where the general population and FFS had longer driving distances. This finding is likely the result of the larger proportion of rural recipients comprising these groups. Further, while considerable variation exists for specific providers and plans, the average distance to the nearest provider for urban/suburban and rural mirror expectations.

Appointment Availability Analysis

As noted earlier, the Provider Network Access Analysis report evaluated three dimensions of access and availability, including the time/distance between recipients and Medicaid providers, recipient-to-provider ratios, and providers' appointment availability. While the ratio and time/distance analyses reflect the infrastructure of the State's Medicaid provider network, appointment availability—assessed via secret shopper calls—provides insight into provider availability. The secret shopper analysis is a critical component to understanding potential barriers to care. Although results from ratio and time/distance analyses may indicate the presence of provider network infrastructure, secret shopper results allow for conclusions regarding recipients' actual access to the network infrastructure.

The secret shopper analysis is divided into four sections to reflect the contractual standards for appointment availability based on provider type, and results are presented in the following order:

- Primary Care Provider Results
- OB/GYN (Prenatal Care) Results, by trimester of pregnancy
- Specialist Results
- Dental Results

Initial outreach calls were made to each sampled provider; however, a case was replaced if the phone number for the originally sampled provider was found to be invalid. Examples of scenarios requiring such a replacement include the following:

- Incorrect or disconnected telephone number (i.e., the telephone number for the sampled provider could not be used to reach the provider)
- Exclusion from the eligible study population (e.g., the sampled provider stated that they were a hospitalist or school-based dental program)
- Incorrect specialty (i.e., the sampled provider stated that they did not have the noted specialty)

This process ensured the maximum number of outreach calls were made for each provider category. Overall, at least one case was replaced for each provider category and MCO/Program.

Primary Care Providers (PCPs)

The following section contains the results of telephone calls made to PCPs' offices. Telephone calls were made to PCPs and PCP extenders with the following subspecialties: Family Nurse Practitioners, Family Practice, Federally Qualified Health Center, General Practice, Internal Medicine, and No Specialty or Specialty Code Listed.

In all PCP cases, appointments are expected to be scheduled within two weeks, or 14 calendar days, from a recipient's call. Figure 4-1 shows the call pathway followed by the secret shopper callers when attempting to contact PCP offices. The diagram provides a high level visual representation of the different outcomes for the outreach calls. Decision points are identified with diamonds while key outcomes are displayed in boxes.

Figure 4-1—PCP Outreach Call Outcome Map for Sampled Cases

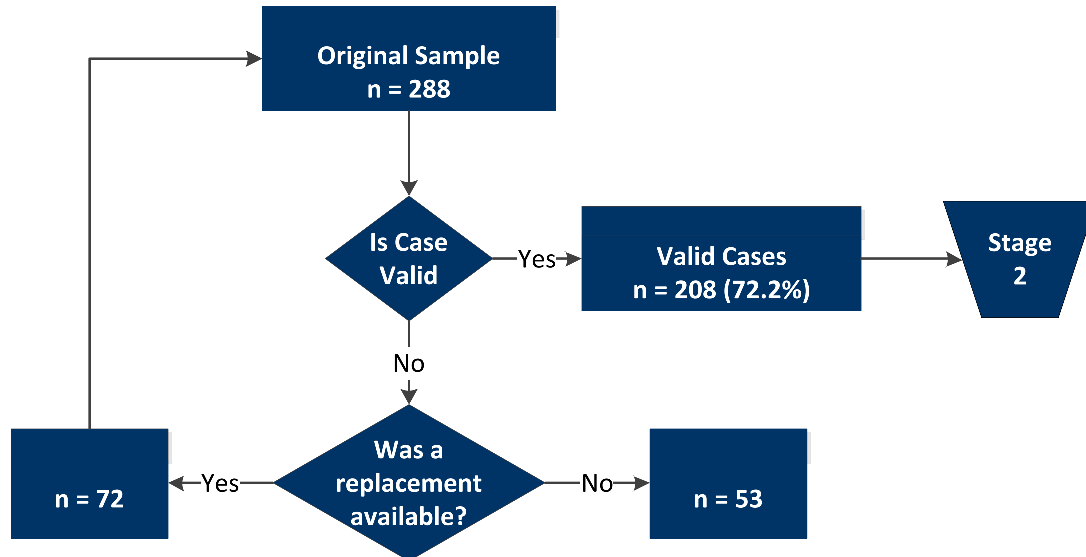


Figure 4-1 shows the process outcomes associated with calls to sampled PCPs, in which 288 PCP cases were initially selected for analysis and 125 cases (43.4 percent) required replacement. However, replacement cases were only available for 72 cases since the total number of cases requiring replacement exceeded the number of initially sampled and oversampled cases. As a result, 208 PCPs had the appropriate specialty and valid contact information for further analysis. The majority of reasons for case replacement involved providers excluded from the PCP study category, including hospitalists or providers working in specialized care facilities (senior care and emergency room facilities). All reasons for case replacement are detailed in Appendix D.

Table 4-12 presents the overall and MCO/Program-specific results of telephone calls to sampled PCPs, including the original number of sampled cases, the total number of calls, the number and percent of replaced cases, and the final number of sampled cases.

Table 4-12—Overall Telephone Outreach Outcomes for PCPs by FFS and MCO

MCO/Program	Original Sample[A]	Total Calls	Replaced Cases		Invalid Replacement Cases	Final Sample[B]
			Number	Percent		
FFS	96	120	45	46.9%	9	66
AGP	96	120	39	40.6%	8	73
HPN	96	120	41	42.7%	10	69
Total	**288**	**360**	**125**	**43.4%**	**27**	**208**

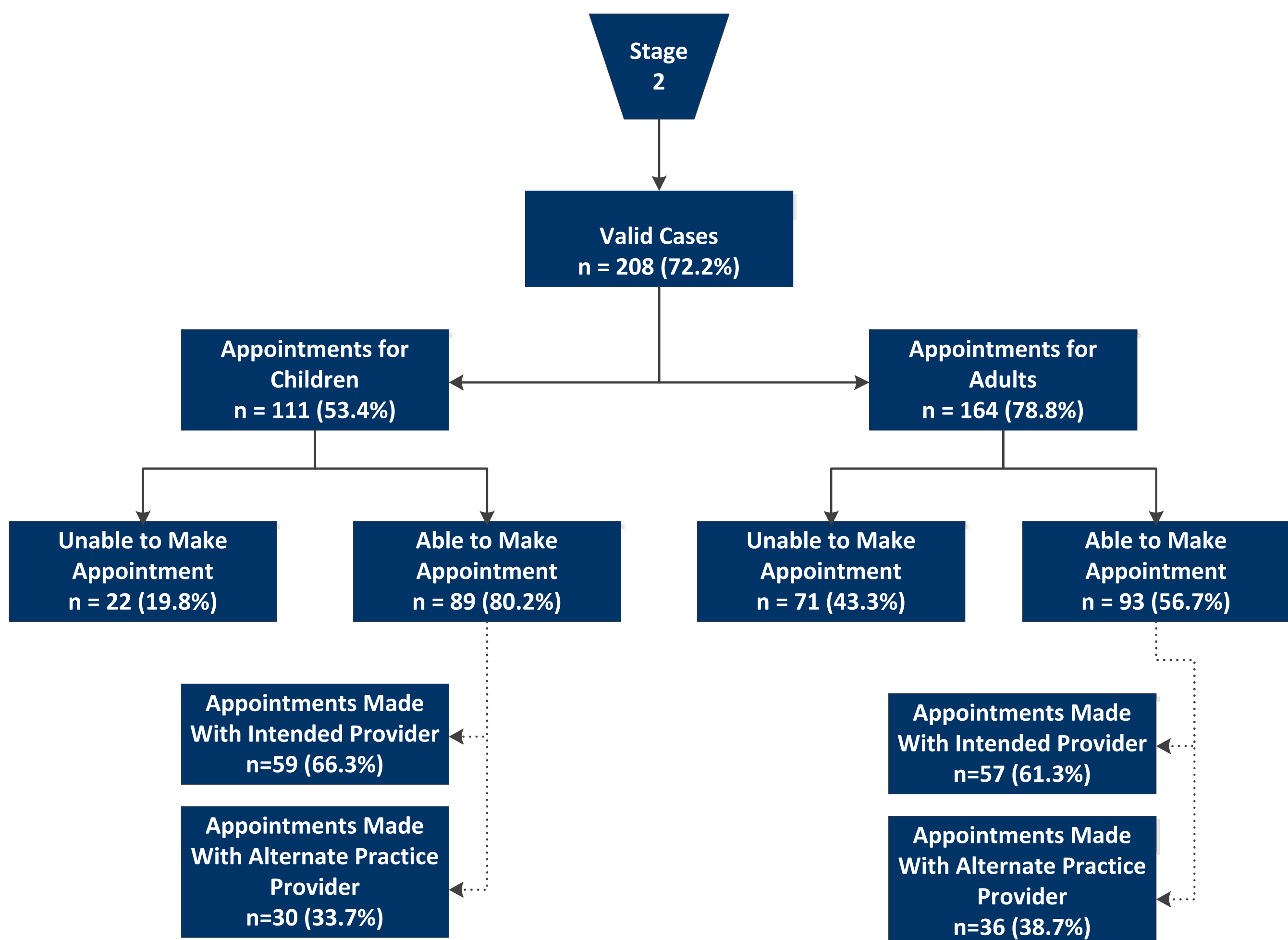
[A] Counts in Table 4-1 includes outreach calls to pediatricians.
[B] Due to the loss in sample size due to invalid cases and insufficient replacement samples the degree of precision in the PCP secret shopper results is reduced. A final sample of 208 will leads to a 95 percent confidence level and 6.8 percent margin of error.

Among the 288 cases selected for telephone outreach, 125 cases (43.4 percent) required replacement. Valid contact information was available for 208 cases (72.2 percent of the sample); however, several replacement cases were invalid (27 cases, 21.6 percent of replaced cases). With a

range of 6.3 percentage points, the MCOs and FFS had slight differences in the percentage of cases requiring a replacement. At 46.9 percent, FFS providers had the greatest percentage of replaced cases, and AGP had the smallest percentage of replaced cases (40.6 percent). These findings suggest that close to half of all new patients may require assistance from the MCOs to schedule a routine appointment with a PCP, and that FFS recipients would need to contact their local Medicaid District Office.

Similar to Figure 4-1, Figure 4-2 shows a high-level visual representation of the different outcomes among the valid PCP cases, and key outcomes are displayed in boxes.

Figure 4-2—PCP Outreach Call Outcome Map for Valid Cases



While all providers contacted were identified as PCPs or PCP extenders, some providers reported only seeing adult patients or children; as a result, the survey results for PCPs are presented by age group (i.e., adults or children). Over half (53.4 percent) of the PCPs contacted reported they provide services to children and 78.8 percent of the contacted PCPs provide primary care services for adults. Overall, secret shoppers were able to schedule appointments for adults with 56.7 percent of PCPs (93 cases) and appointments for children with 80.2 percent of PCPs (89 cases). Among appointments for adults, 61.3 percent (57 cases) of outreach calls resulted in an appointment with the intended provider, and 66.3 percent of outreach calls for children resulted in an appointment

with the intended provider (59 cases). Detailed results on replacement cases and appointment status results by PCP specialty are located in Appendix D. The remaining tables in this section highlight detailed results by MCO/Program for each of the key outcomes along the process map shown in Figure 4-2.

Table 4-13 displays the appointment status results for adults overall and by MCO/Program, including the number and percent of sampled cases in which callers were able or unable to schedule a routine appointment with a PCP.

Table 4-13—Number and Percent of Outreach Calls to PCPs Regarding Appointments for Adults by Appointment Status for FFS and MCOs

MCO/Program	Final Sample*	Able to Schedule Appointment		Unable to Schedule Appointment	
		Number	Percent	Number	Percent
FFS	56	35	62.5%	21	37.5%
AGP	52	33	63.5%	19	36.5%
HPN	56	25	44.6%	31	55.4%
Total[A]	**164**	**93**	**56.7%**	**71**	**43.3%**

[A] Does not include outreach calls to pediatricians; pediatric results are displayed in Table 4-16 and Table 4-17.

Among PCPs providing services to adults, callers were able to schedule appointments for 56.7 percent of cases, although this percentage varied by 18.9 percentage points across MCO/Program. AGP and FFS had similar percentages of cases able to schedule appointments for adult patients (63.5 percent for AGP and 62.5 percent for FFS). HPN contributed the largest number of cases in which the caller was unable to schedule an appointment for an adult patient (55.4 percent).

Table 4-14 highlights the reasons for being unable to schedule an appointment with a PCP for an adult.

Table 4-14—Reasons for Incomplete Appointments with PCPs Regarding Appointments for Adults by FFS and MCOs

Reasons for Incomplete Appointments	Total[A]	FFS		AGP		HPN	
		Number	Percent	Number	Percent	Number	Percent
Unable to Reach Appointment Scheduling Staff	23	9	42.9%	9	47.4%	5	16.1%
Not Contracted With Health Plan	21	8	38.1%	4	21.1%	9	29.0%
Not Accepting New Patients	11	0	0.0%	2	10.5%	9	29.0%
Require Action Prior to Appointment	8	2	9.5%	3	15.8%	3	9.7%
Other[B]	4	0	0.0%	1	5.3%	3	9.7%
Panel Limitation	4	2	9.5%	0	0.0%	2	6.5%
Total[A]	**71**	**21**	**100%**	**19**	**100%**	**31**	**100%**

[A] Does not include outreach calls to pediatricians; pediatric results are displayed in Table 4-16 and Table 4-17 .
[B] "Other" reasons for incomplete appointments include walk-in clinics and multi-location practices in which the sampled provider was not available at the telephone number.

Of the 71 cases in which an appointment could not be scheduled, 23 cases (32.4 percent) were due to the caller being unable to reach the appointment scheduling staff, and 21 cases (29.6 percent) were due to the PCP no longer being contracted with the health plan. Among FFS providers, these two categories comprised 81.0 percent of incomplete appointments while reasons for incomplete appointments for MCOs were distributed more evenly across categories. HPN exhibited the highest percentage of calls without an appointment for adults and accounted for 43.7 percent of the incomplete appointment calls. Nearly 60 percent of incomplete appointments for HPN resulted from PCPs no longer contracting with the health plan or not accepting new patients. Overall, 11.3 percent of incomplete appointments resulted from providers requiring preliminary actions by the caller before scheduling an appointment, including designating the provider as the caller's PCP, completing paperwork, or registering on the internet with the provider's office.

Table 4-15 describes the minimum, maximum, and average days to an appointment as well as the percentage of calls that resulted in an appointment within two weeks, or 14 calendar days, of the outreach call.

Table 4-15—Average Time to Appointment for PCPs Taking Appointments for Adults by FFS and MCOs

MCO/Program	Total Calls[A]	Calls with Appointment		Calendar Days to Appointment			Appointments Within 14 Days[B]	
		Number	Percent	Min	Max	Average	Number	Percent
FFS	56	35	62.5%	0	74	17	21	60.0%
AGP	52	33	63.5%	1	80	28	13	39.4%
HPN	56	25	44.6%	2	116	24	12	48.0%
Total[A]	**164**	**93**	**56.7%**	**0**	**116**	**23**	**46**	**49.5%**

[A] Does not include outreach calls to pediatricians; pediatric results are displayed in Table 4-16 and Table 4-17.
[B] Two weeks, or 14 calendar days, is the contract standard for primary care appointments.

Overall, only 56.7 percent (or 93) of the calls resulted in being able to schedule a routine primary care appointment. The average days to an appointment was 23 calendar days with wait times ranging from same-day appointments (FFS) to 116 days (HPN). Appointments with FFS providers had an average wait time of 17 days while longer average wait times were noted for AGP and HPN providers (28 days and 24 days, respectively). Overall, only 49.5 percent of the PCP appointments could be scheduled within 14 days of the outreach call. FFS providers exhibited the largest percentage of appointments scheduled within 14 days (i.e., 60.0 percent) whereas AGP or HPN had less than 50 percent.

HSAG evaluated appointment availability for pediatricians and PCPs accepting children as patients. Table 4-16, on the following page, presents the appointment status results for children overall and by MCO/Program, including the number and percent of sample cases in which callers were able or unable to schedule a routine appointment with a PCP.

Table 4-16—Number and Percent of Outreach Calls to PCPs Taking Appointments for Children by Appointment Status for FFS and MCOs					
		Able to Schedule Appointment		Unable to Schedule Appointment	
MCO/Program	Final Sample	Number	Percent	Number	Percent
FFS	32	26	81.3%	6	18.8%
AGP	43	33	76.7%	10	23.3%
HPN	36	30	83.3%	6	16.7%
Total	**111**	**89**	**80.2%**	**22**	**19.8%**

Among PCPs providing services to children, callers were able to schedule appointments for 80.2 percent of the calls although this percentage varied by 6.6 percentage points across MCOs and the FFS Program. While AGP had the highest percentage of PCPs that reported providing services to children (38.7 percent), it also had the largest percentage of cases where an appointment was unable to be scheduled (23.3 percent). The most frequent reason for being unable to schedule an appointment for a child (8 cases or 36.4 percent) was the provider requiring additional action from the caller prior to appointment scheduling. Other common reasons callers were unable to schedule an appointment for a child included providers no longer being contracted with the MCO/Program and callers being unable to reach the scheduling staff.

Table 4-17 describes the minimum, maximum, and average days to an appointment as well as the percentage of calls where an appointment was scheduled within two weeks, or 14 calendar days.

Table 4-17—Average Time to Appointment for PCPs Taking Appointments for Children by FFS and MCOs								
		Calls with Appointment		Calendar Days to Appointment			Appointments Within 14 Days[A]	
MCO/Program	Total Calls	Number	Percent	Min	Max	Average	Number	Percent
FFS	32	26	81.3%	0	40	9	22	84.6%
AGP	43	33	76.7%	0	80	20	19	57.6%
HPN	36	30	83.3%	0	117	18	21	70.0%
Total	**111**	**89**	**80.2%**	**0**	**117**	**16**	**62**	**69.7%**

[A] Two weeks, or 14 calendar days, is the contract standard for primary care appointments.

Overall, approximately four of every five calls (80.2 percent, or 89 calls) to a PCP's office resulted in an appointment. On average, recipients' appointments were 16 days from the outreach call. Moreover, 69.7 percent of appointments were scheduled within 14 days. FFS providers had both the shortest average wait time (9 days) and the largest percentage of scheduled appointments within 14 days (84.6 percent). AGP providers had the longest average wait time (20 days) and the smallest proportion of appointments within 14 days (57.6 percent).

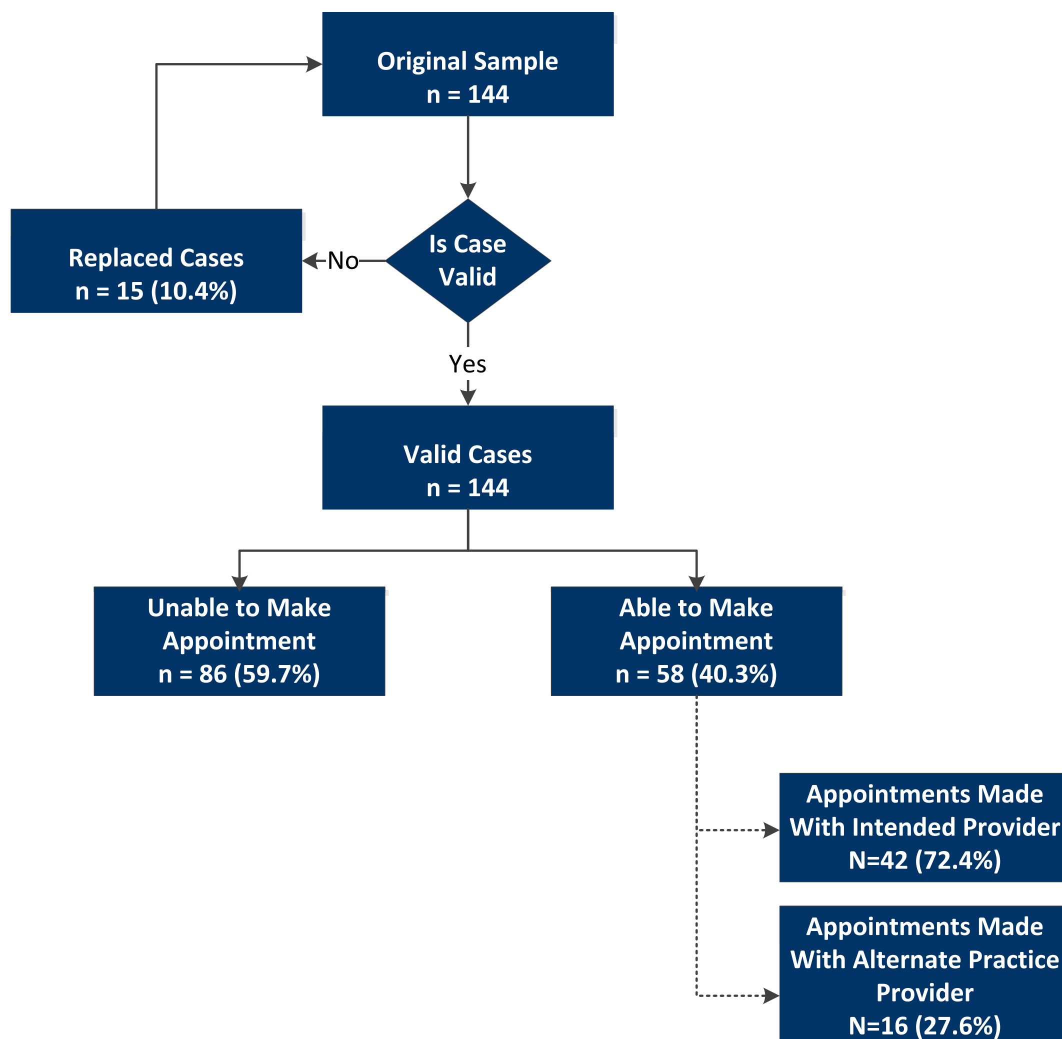
OB/GYN Results

First and Second Trimester Appointments

The following section contains the results of outreach calls to prenatal care providers (primarily physicians with a specialty in OB/GYN) requesting appointments for women in the first or second trimester of pregnancy. While the provider ratio and time/distance analyses reported OB/GYNs together with PCPs, the secret shopper survey analyzed them separately to account for differences in the contract standards between the two types of providers. For women in the first or second trimester of pregnancy, appointments are expected to be scheduled within seven calendar days of a recipient's call.

Figure 4-3 shows the call pathway followed by the secret shopper callers when scheduling appointments with prenatal care provider offices. The diagram provides a high level visual representation of the different outcomes for the outreach calls. Decision points are identified with diamonds while key outcomes are displayed in boxes.

Figure 4-3—OB/GYN First and Second Trimester Outreach Call Outcome Map



Of the 144 sampled cases, only 15 cases (10.4 percent) required a replacement, and callers attempted to contact a total of 159 cases. For women in their first or second trimester of pregnancy, only 40.3 percent (58 cases) of the calls resulted in an appointment. The most frequent reasons for replacement cases included seven cases with invalid telephone numbers and seven cases with incorrect provider specialties. FFS providers contributed the largest proportion of cases requiring replacement (60.0 percent of replaced cases), while each MCO contributed 20.0 percent of the overall replaced cases. Detailed results on replacement cases and appointment status results by prenatal care specialty are located in Appendix D.

Table 4-18 presents the appointment status results overall and by MCO/Program, including the number and percent of sampled cases in which callers were able or unable to schedule an appointment.

Table 4-18—Number and Percent of Outreach Calls to OB/GYN Providers by Appointment Status for FFS and MCOs for First and Second Trimester Prenatal Care

MCO/Program	Final Sample	Able to Schedule Appointment		Unable to Schedule Appointment	
		Number	Percent	Number	Percent
FFS	48	16	33.3%	32	66.7%
AGP	48	22	45.8%	26	54.2%
HPN	48	20	41.7%	28	58.3%
Total	**144**	**58**	**40.3%**	**86**	**59.7%**

In general, callers were only able to schedule appointments in approximately 40 percent of the calls, with some variation noted across MCO/Program. Calls to AGP providers reflected the largest proportion of scheduled appointments (45.8 percent) while FFS providers were associated with the smallest proportion of scheduled appointments (33.3 percent).

Table 4-19 highlights the reasons the callers were unable to schedule appointments.

Table 4-19—Reasons for Incomplete Appointments with OB/GYN Providers by FFS and MCOs for First and Second Trimester Prenatal Care

Reasons for Incomplete Appointments	Total	FFS		AGP		HPN	
		Number	Percent	Number	Percent	Number	Percent
Require Pre-Appointment Screening	25	3	9.4%	7	26.9%	15	53.6%
Unable to Reach Appointment Scheduling Staff	16	7	21.9%	6	23.1%	3	10.7%
Require Pre-Registration with Practice	12	4	12.5%	4	15.4%	4	14.3%
Not Taking Medicaid/Plan	9	8	25.0%	0	0.0%	1	3.6%
Gestational Age Requires Physician Approval	7	3	9.4%	3	11.5%	1	3.6%
Not Accepting New Patients	7	2	6.3%	3	11.5%	2	7.1%
No Appointments Available	3	2	6.3%	1	3.8%	0	0.0%
Referral Required	3	2	6.3%	0	0.0%	1	3.6%

Table 4-19—Reasons for Incomplete Appointments with OB/GYN Providers by FFS and MCOs for First and Second Trimester Prenatal Care							
Reasons for Incomplete Appointments	Total	FFS		AGP		HPN	
		Number	Percent	Number	Percent	Number	Percent
Panel Restrictions[A]	2	1	3.1%	1	3.8%	0	0.0%
Require Prior Action Before Appointment	2	0	0.0%	1	3.8%	1	3.6%
Total	**86**	**32**	**100%**	**26**	**100%**	**28**	**100%**

[A] Panel Restrictions include providers that limit new patients based on strict gestational age criteria, or only accept recipients with high risk pregnancies with or without a referral.

For the majority of outreach calls to valid providers (59.7 percent), callers were unable to schedule an appointment. Table 4-19 highlights the primary reasons for incomplete appointments involving the physician offices requiring pre-appointment screenings (29.1 percent) and callers being unable to reach appointment scheduling staff (18.6 percent). The distribution of reasons that impacted callers' ability to schedule appointments varied by MCOs and by program. Nearly two-thirds (64.3 percent) of incomplete appointments with HPN providers resulted from pre-appointment screening requirements or an inability to reach appointment scheduling staff. However, only 31.3 percent of incomplete appointments with FFS providers were attributed to these reasons. A small number of incomplete appointments were due to providers requiring pre-registration with the practice (14.0 percent), providers no longer accepting Medicaid (10.5 percent), restrictions on appointment availability based on gestational age (8.1 percent), or providers not accepting new patients (8.1 percent).

Table 4-20 displays the minimum, maximum, and average calendar days to an appointment as well as the percentage of appointments that meet contract standards (i.e., an appointment within seven calendar days).

Table 4-20—Average Time to Appointment for OB/GYN Providers by FFS and MCOs for First and Second Trimester Prenatal Care								
MCO/Program	Total Calls	Calls with Appointment		Calendar Days to Appointment			Appointments Within 7 Days[A]	
		Number	Percent	Min	Max	Average	Number	Percent
FFS	48	16	33.3%	7	43	20	1	6.3%
AGP	48	22	45.8%	2	101	22	9	40.9%
HPN	48	20	41.7%	0	48	17	4	20.0%
Total	**144**	**58**	**40.3%**	**0**	**101**	**20**	**14**	**24.1%**

[A] Seven calendar days is the contract standard for prenatal appointments for women in their first or second trimesters of pregnancy.

Overall, the average time to schedule a prenatal appointment for women in the first or second trimester of pregnancy was 20 calendar days, with individual MCO/Program results ranging from 0 to 22 calendar days. Overall, only 24.1 percent of appointments were in compliance with contractual standards, though the percentage of appointments in compliance with appointment availability standards varied by 34.6 percentage points across the MCOs and the FFS program. FFS prenatal care providers had the smallest range of days to an appointment (36 calendar days), and these providers

had the smallest proportion of appointments with wait times in compliance with contractual standards (6.3 percent). Although AGP providers had the largest range of calendar days to an appointment (99 days) and the longest average wait time (22 days), AGP had the largest percentage of appointments in compliance with contractual standards (40.9 percent).

The proportion of appointments scheduled with the intended provider by specialist category and MCO/Program is displayed in Appendix D.

Third Trimester Appointments

The following section contains the results of telephone calls made to prenatal care providers (primarily physicians with a specialty in OB/GYN) requesting appointments for women in the third trimester of pregnancy. For women in the third trimester of pregnancy, appointments are expected to be scheduled within three calendar days of a recipient’s call.

Figure 4-4 shows the call pathway followed by the secret shopper callers when scheduling appointments with prenatal care provider offices. The diagram provides a high level visual representation of the different outcomes for the outreach calls. Decision points are identified with diamonds while key outcomes are displayed in boxes.

Figure 4-4—OB/GYN Third Trimester Outreach Call Outcome Map

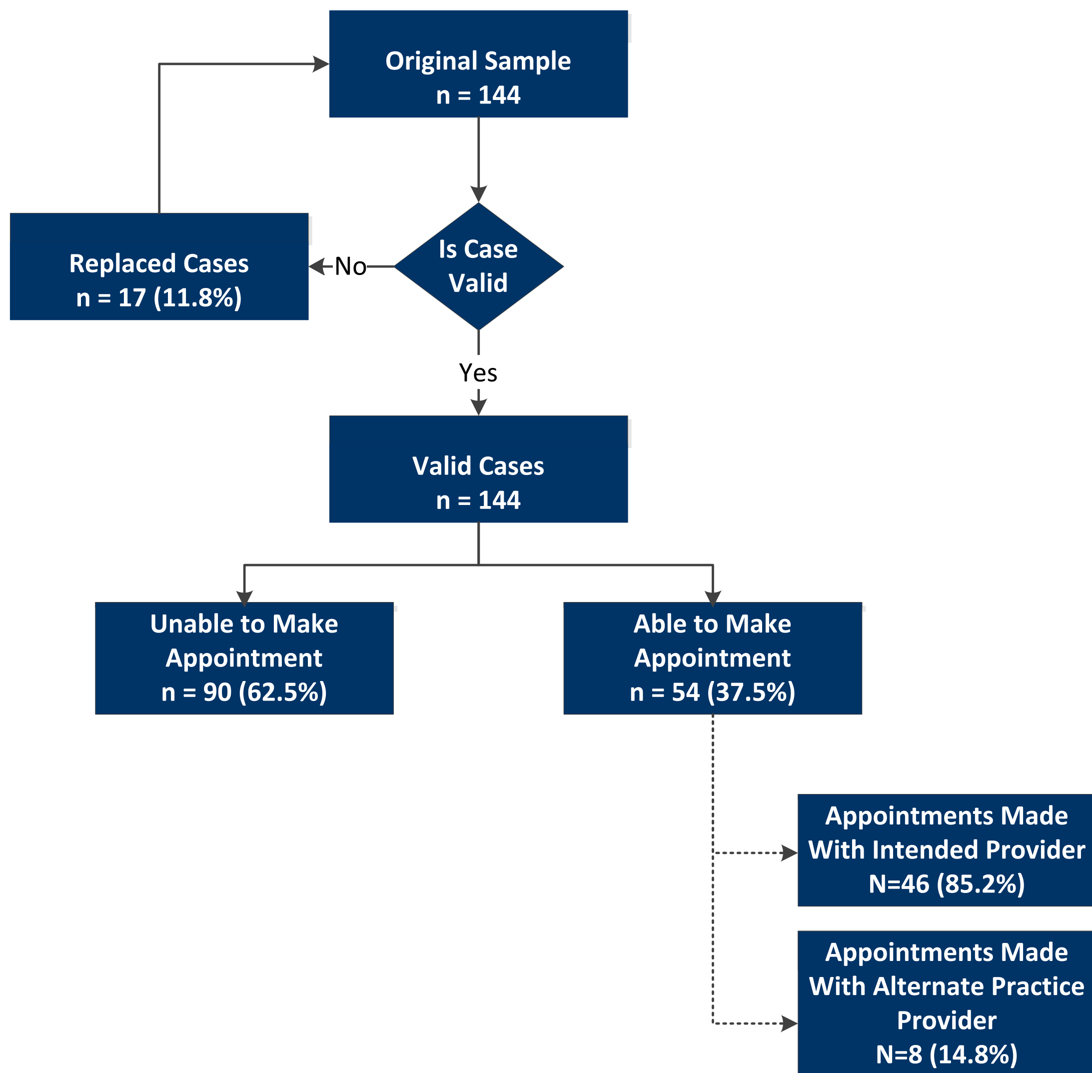


Figure 4-4 shows the outcomes associated with outreach calls to OB/GYN providers for prenatal care during the third trimester of pregnancy, in which 144 cases were sampled for analysis and 17 cases (11.8 percent) required replacement, resulting in callers attempting to contact a total of 161 cases. More than half of replacement cases (52.9 percent) were for FFS providers. Detailed information on all reasons cases were replaced is located in Appendix D. Callers were able to schedule appointments in 37.5 percent of cases, and the most common reasons for incomplete appointments noted by callers included pre-appointment screening requirements, panel restrictions, and callers being unable to reach appointment scheduling staff. Overall, 85.2 percent of appointments were scheduled with the intended provider. Detailed results on replacement cases and appointment status results by OB/GYN specialty are located in Appendix D. The following tables highlight detailed results by MCO/Program for each of the key outcomes along the process map shown in

Figure 4-4.

Table 4-21 presents appointment status results overall and by MCO/Program, including the number and percent of sampled cases in which callers were able or unable to schedule an appointment.

Table 4-21—Number and Percent of Outreach Calls to OB/GYN Providers by Appointment Status for FFS and MCOs for Third Trimester Prenatal Care

MCO/Program	Final Sample	Able to Schedule Appointment		Unable to Schedule Appointment	
		Number	Percent	Number	Percent
FFS	48	15	31.3%	33	68.8%
AGP	48	22	45.8%	26	54.2%
HPN	48	17	35.4%	31	64.6%
Total	**144**	**54**	**37.5%**	**90**	**62.5%**

Overall, callers were able to schedule appointments with 37.5 percent of prenatal care providers, and this percentage varied across the MCOs and the FFS program, ranging from 31.3 percent for FFS to 45.8 percent for AGP. Table 4-22 highlights the reasons the callers identified for being unable to schedule an appointment for prenatal care during the third trimester of pregnancy.

Table 4-22—Reasons for Incomplete Appointments with OB/GYN Providers by FFS and MCOs for Third Trimester Prenatal Care

Reasons for Incomplete Appointments	Total	FFS		AGP		HPN	
		Number	Percent	Number	Percent	Number	Percent
Require Pre-Appointment Screening	37	13	39.4%	11	42.3%	13	41.9%
Panel Restrictions*	15	5	15.2%	5	19.2%	5	16.1%
Unable to Reach Appointment Scheduling Staff	11	5	15.2%	4	15.4%	2	6.5%
Not Accepting New Patients	7	2	6.1%	2	7.7%	3	9.7%
Not Taking Medicaid/Plan	7	2	6.1%	1	3.8%	4	12.9%
Gestational Age Requires Physician Approval	6	4	12.1%	1	3.8%	1	3.2%
No Appointments Available	4	2	6.1%	1	3.8%	1	3.2%
Require Pre-Registration with Practice	2	0	0.0%	0	0.0%	2	6.5%
Require Action Prior to Appointment	1	0	0.0%	1	3.8%	0	0.0%
Total	**90**	**33**	**100%**	**26**	**100%**	**31**	**100%**

* Panel Restrictions include physicians that only accept recipients with high risk pregnancies or require recipients to be referred to the practice.

A majority of valid prenatal care providers could not schedule an appointment for callers in the third trimester of pregnancy, and Table 4-22 shows that overall, the primary reasons for incomplete appointments included providers requiring pre-appointment screenings (41.1 percent), providers

with panel restrictions (16.7 percent), and callers being unable to reach appointment scheduling staff (12.2 percent). These reasons represent the majority of incomplete appointments for MCOs and FFS. Additionally, 7.8 percent of incomplete appointments were due to providers not accepting new patients, 7.8 percent of incomplete appointments were due to providers no longer accepting Medicaid, and 6.7 percent of incomplete appointments were due to provider imposing restrictions based on the recipient's specific stage in the pregnancy (i.e., gestational age of the fetus).

Table 4-23 displays the minimum, maximum, and average calendar days to an appointment as well as the percentage of appointments that meet contractual requirements (i.e., an appointment within three calendar days).

Table 4-23—Average Time to Appointment for OB/GYN Providers by FFS and MCOs for Third Trimester Prenatal Care

MCO/Program	Total Calls	Calls with Appointment		Days to Appointment			Appointments Within Three Days[A]	
		Number	Percent	Min	Max	Average	Number	Percent
FFS	48	15	31.3%	1	50	15	3	20.0%
AGP	48	22	45.8%	0	45	18	4	18.2%
HPN	48	17	35.4%	1	49	15	3	17.6%
Total	**144**	**54**	**37.5%**	**0**	**50**	**16**	**10**	**18.5%**

[A] Three calendar days is the contract standard for prenatal appointments for women in their third trimester of pregnancy.

Overall, only 54 of the 144 outreach calls to prenatal care providers (37.5 percent), resulted in an appointment for a woman in the third trimester of pregnancy, and the average wait time for an appointment was 16 calendar days. Although AGP's OB/GYNs had the smallest overall range of days to an appointment (45 days), these providers had the longest average wait time for an appointment (18 days). FFS and HPN providers had an average wait time of 15 days for an appointment. Overall, 18.5 percent of providers offered appointments in compliance with the appointment availability standard, and this percentage varied by 2.4 percentage points across the MCOs and the FFS program. FFS providers had the largest proportion of appointments scheduled in compliance with contract standards for appointment availability (20.0 percent).

Specialist Results

The following section contains the results of telephone calls made to specialist provider offices. Calls were made to the following specialties and subspecialties[18]:

- Cardiology – Cardiovascular
- Cardiology – Cardiovascular Surgery
- Cardiology – Vascular Surgery
- Dermatology – Dermatology
- Ear, Nose and Throat – Otolaryngology
- Gastroenterology – Gastroenterology

[18] Provider specialties listed may not represent all provider specialties assessed during SFY 2015 network adequacy activities.

- General Surgery – General Surgery
- Maternal/Fetal Medicine – Neonatology, Pediatrics
- Mental Health Outpatient Services – Clinical Psychologist
- Mental Health Outpatient Services – Counseling Services
- Mental Health Outpatient Services – No Specialty
- Mental Health Outpatient Services – Unknown Provider Specialty, LCPC
- Mental Health Outpatient Services – Unknown Provider Specialty, LCSW
- Mental Health Outpatient Services – Unknown Provider Specialty, LMFT
- Nephrology – Nephrology
- Neurology – Neurology
- Orthopedic Medicine – Orthopedic Surgery
- Other Surgeries – Reconstructive Surgery
- Pediatric Mental Health Specialist – Psychiatry – Child
- Pediatric Physical Health Specialists – Pediatric Cardiology
- Pediatric Physical Health Specialists – Pediatric Surgery
- Psychiatry – Psychiatry
- Pulmonary Medicine – Pulmonary Diseases
- Rehabilitation – No Specialty Code Listed
- Rehabilitation – No Specialty
- Rehabilitation – Occupational Therapy
- Rehabilitation – Pain Management
- Rehabilitation – Physical Medicine/Rehab
- Rehabilitation – Physical Therapy
- Rehabilitation – Speech Pathologist
- Rehabilitation – Speech Pathologist (Language)
- Urology – Urologic Surgery
- Vision – No Specialty
- Vision – Ophthalmology

In all specialist cases, appointments are expected to be scheduled within 30 calendar days of a recipient's call.

Figure 4-5 shows the call pathway followed by the secret shopper callers when scheduling appointments with specialist provider offices. The diagram provides a high level visual representation of the different outcomes for the calls. Decision points are identified with diamonds while key outcomes are displayed in boxes.

Figure 4-5—Specialist Outreach Call Outcome Map

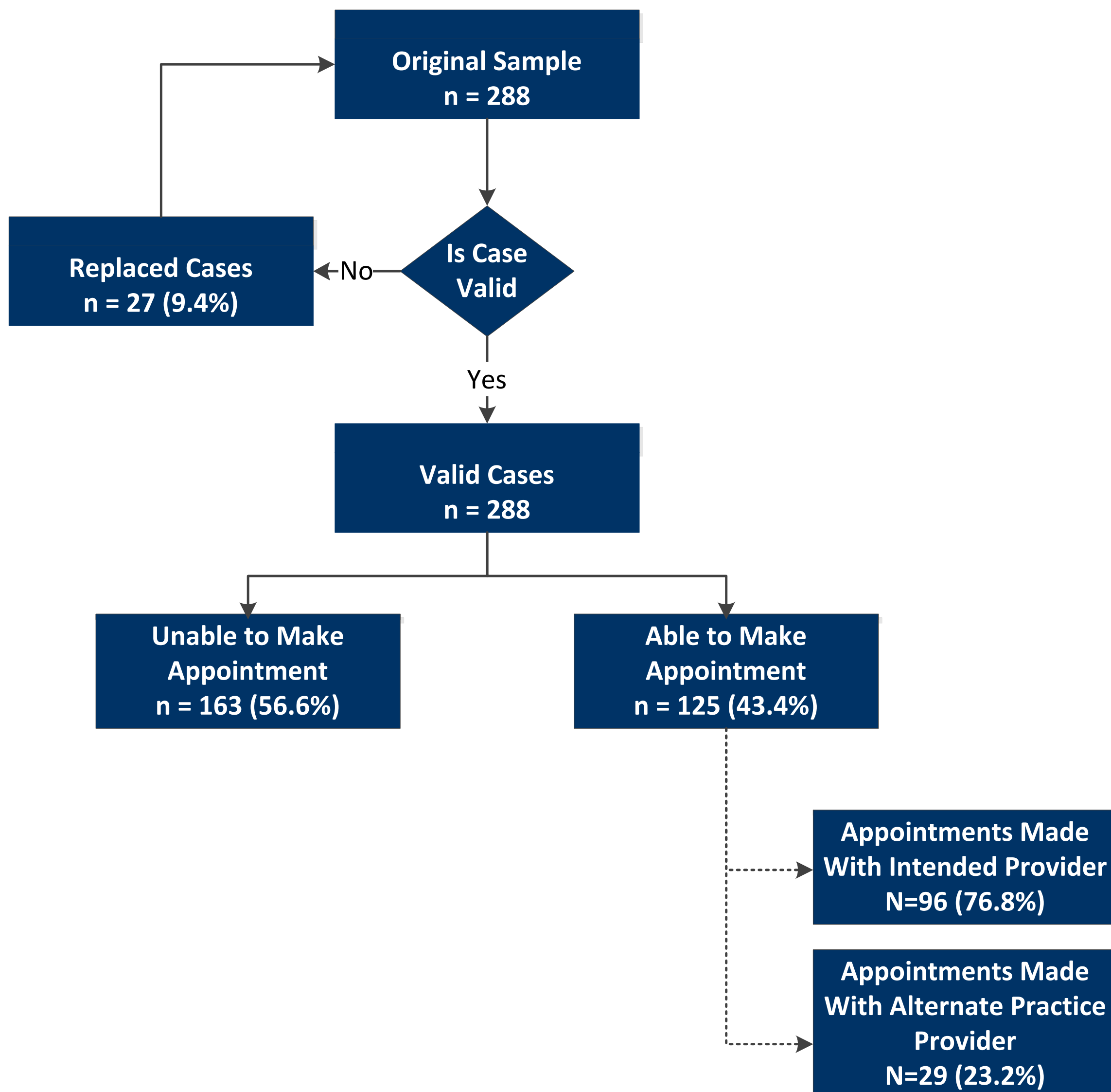

Original Sample
n = 288
Is Case Valid
No
Replaced Cases
n = 27 (9.4%)
Yes
Valid Cases
n = 288
Unable to Make Appointment
n = 163 (56.6%)
Able to Make Appointment
n = 125 (43.4%)
Appointments Made With Intended Provider
N=96 (76.8%)
Appointments Made With Alternate Practice Provider
N=29 (23.2%)

Figure 4-5 shows the outcomes associated with calls to sampled specialist providers, in which 288 cases were initially selected for analysis in the specialist study category and 27 cases (9.4 percent) required replacement, resulting in callers attempting to contact a total of 315 cases. Factors that resulted in a replacement of sampled cases included 15 cases with invalid telephone numbers, eight cases with incorrect provider specialties, and four cases with study exclusions (e.g., hospitalists).The majority of cases requiring replacement were FFS providers (51.9 percent of replaced providers). Overall, callers were able to schedule appointments for less than half (43.4 percent) of the 288 valid cases. However, 76.8 percent of scheduled appointments were available with the intended provider, and the remaining 23.2 percent of appointments were scheduled with an alternate provider at the same location. Detailed results on replacement cases and appointment status results by specialty are located in Appendix D.

Table 4-24 presents the appointment status results overall and by MCO/Program, including the number and percent of sampled cases in which callers were able or unable to schedule an appointment with the specialist provider.

Table 4-24—Number and Percent of Outreach Calls to Specialist Providers by Appointment Status for FFS and MCOs

MCO/Program	Final Sample	Able to Schedule Appointment		Unable to Schedule Appointment	
		Number	Percent	Number	Percent
FFS	96	44	45.8%	52	54.2%
AGP	96	41	42.7%	55	57.3%
HPN	96	40	41.7%	56	58.3%
Total	**288**	**125**	**43.4%**	**163**	**56.6%**

Overall, callers were able to successfully schedule an appointment with a specialist provider for 43.4 percent of valid cases. The percentage of completed appointments varied minimally across the MCOs and the FFS program, ranging from 41.7 percent for HPN to 45.8 percent for FFS. Table 4-25 below lists the reasons the callers identified for being unable to schedule an appointment with a specialist provider.

Table 4-25—Reasons for Incomplete Appointments with Specialist Providers by FFS and MCOs

Reasons for Incomplete Appointments	Total	FFS		AGP		HPN	
		Number	Percent	Number	Percent	Number	Percent
Unable to Reach Appointment Scheduling Staff	64	23	44.2%	21	38.2%	20	35.7%
Referral Required	56	18	34.6%	18	32.7%	20	35.7%
Not Accepting Medicaid	14	2	3.8%	6	10.9%	6	10.7%
Not Accepting Health Plan	10	0	0.0%	5	9.1%	5	8.9%
Not Accepting New Patients	7	3	5.8%	2	3.6%	2	3.6%
No Appointments Available	4	3	5.8%	1	1.8%	0	0.0%
Require Prior Testing Results	4	2	3.8%	0	0.0%	2	3.6%

Table 4-25—Reasons for Incomplete Appointments with Specialist Providers by FFS and MCOs							
Reasons for Incomplete Appointments	Total	FFS		AGP		HPN	
		Number	Percent	Number	Percent	Number	Percent
Require Prior Action Before Appointment	2	1	1.9%	0	0.0%	1	1.8%
Panel Restrictions	1	0	0.0%	1	1.8%	0	0.0%
Require Pre-Appointment Screening	1	0	0.0%	1	1.8%	0	0.0%
Total	**163**	**52**	**100%**	**55**	**100%**	**56**	**100%**

Callers were unable to obtain an appointment with the majority (56.6 percent) of the specialist providers. Table 4-25 shows the primary reasons callers identified for incomplete appointments including being unable to reach appointment scheduling staff (39.3 percent) or the provider requiring a referral from another provider prior to scheduling an appointment (34.4 percent). Both MCOs and the FFS program had a similar percentage of specialists citing the aforementioned reasons for incomplete appointments (representing 78.8 percent, 70.9 percent, and 71.4 percent of FFS, AGP, and HPN incomplete appointments, respectively). However, greater variation was seen across the MCOs and FFS program for other reasons, including incomplete appointments in which callers indicated that the provider no longer accepted Medicaid (8.6 percent overall, but slightly over 10 percent for AGP and HPN providers), and callers reporting that the provider no longer accepted the health plan (6.1 percent overall, and approximately 9.0 percent for AGP and HPN providers). Combined, these reasons accounted for 20.0 percent and 19.6 percent of incomplete appointments for AGP and HPN specialists, respectively.

Table 4-26 displays the minimum, maximum, and average calendar days to an appointment as well as the percentage of appointments that met contractual requirements (i.e., an appointment within 30 calendar days).

Table 4-26—Average Time to Appointment for Specialist Providers by FFS and MCOs								
MCO/Program	Total Calls	Calls with Appointment		Calendar Days to Appointment			Appointments Within 30 Days[A]	
		Number	Percent	Min	Max	Average	Number	Percent
FFS	96	44	45.8%	0	51	11	41	93.2%
AGP	96	41	42.7%	0	84	16	36	87.8%
HPN	96	40	41.7%	0	107	20	31	77.5%
Total	**288**	**125**	**43.4%**	**0**	**107**	**15**	**108**	**86.4%**

[A] 30 calendar days is the contract standard for appointments specialist providers.

At 15 calendar days, the average time to an appointment with a specialist was below the appointment availability standard, and MCO/Program results had a range of nine calendar days. Overall, 86.4 percent of cases offered an appointment in compliance with contractual standards, though this percentage varied widely across the MCOs and the FFS program (15.7 percentage points). FFS specialists had both the shortest maximum wait time for an appointment (51 days) and the largest proportion of appointments in compliance with contract standards (93.2 percent), while HPN had the longest maximum wait time for an appointment (107 days) and the smallest proportion of appointments in compliance with contract standards.

Dental Results

The following section contains the results of telephone calls made to dental provider offices. In addition to general and family dentists, calls were made to the following dental specialties:

- Dental Hygienists
- Oral Surgeon
- Orthodontists
- Pediatric Dentists

In all dental cases, appointments are expected to be scheduled within 30 calendar days of a recipient's call. Figure 4-6 shows the call pathway followed by the secret shopper callers when scheduling appointments with dental offices. The diagram provides a high level visual representation of the different outcomes for the outreach calls. Decision points are identified with diamonds while key outcomes are displayed in boxes.

Figure 4-6—Dental Outreach Call Outcome Map

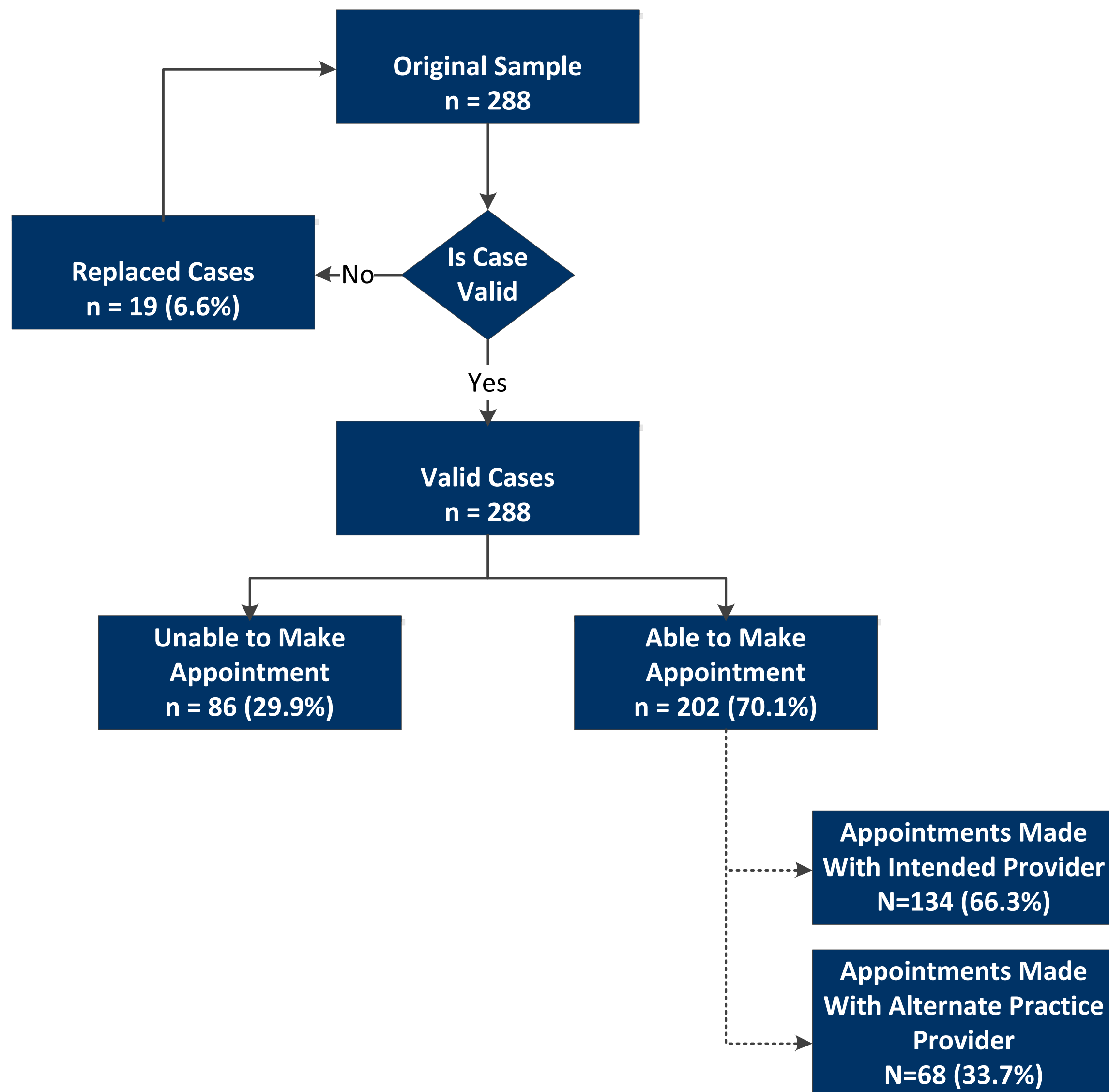


Figure 4-6 shows the outcomes associated with calls to sampled dental providers, in which 288 cases were initially selected for the dental analysis and 19 cases (6.6 percent) required replacement, resulting in callers attempting to contact a total of 307 cases for the dental analysis. Factors that resulted in a replacement of sampled cases included 14 cases with invalid telephone numbers, four cases with study exclusions (e.g., hospitalists or school-based dental programs), and one case with an incorrect provider specialty. Detailed information on the reasons cases were replaced is located in Appendix D. Overall, 70.1 percent (202 cases) of calls made to the 288 valid dental offices resulted in an appointment. Two-thirds of appointments were scheduled with the specific provider selected for the study and the remaining appointments were scheduled with an alternate provider at the same location. Detailed results on replacement cases and appointment status results by dental specialty are located in Appendix D.

Table 4-27 presents the appointment status results overall and by MCO/Program, including the number and percent of sampled cases in which callers were able or unable to schedule an appointment for routine dental care.

Table 4-27—Number and Percent of Outreach Calls to Dental Providers by Appointment Status for FFS and MCOs					
MCO/Program	Final Sample	Able to Schedule Appointment		Unable to Schedule Appointment	
		Number	Percent	Number	Percent
FFS	96	66	68.8%	30	31.3%
AGP	96	61	63.5%	35	36.5%
HPN	96	75	78.1%	21	21.9%
Total	**288**	**202**	**70.1%**	**86**	**29.9%**

Overall, callers were able to successfully schedule a dental appointment with 70.1 percent of valid providers in the dental sample. Individual performance by plans varied, with the lowest number of appointments scheduled for recipients enrolled in Amerigroup (AGP, 63.5 percent) and the highest number scheduled for recipients enrolled in Health Plan of Nevada (HPN, 78.1 percent). However, nearly one-third (29.9 percent) of all telephone calls ended without an appointment being scheduled by the caller, and this percentage varied by nearly 15 percentage points among the MCOs and the FFS program. Table 4-28 highlights the reasons the callers identified for being unable to schedule an appointment with a dental provider.

Table 4-28—Reasons for Incomplete Appointments with Dental Providers by FFS and MCOs							
Reasons for Incomplete Appointments	Total Incomplete Appointments	FFS		AGP		HPN	
		#	%	#	%	#	%
Not Accepting Medicaid	31	14	46.7%	9	25.7%	8	38.1%
Unable to Reach Appointment Scheduling Staff	18	6	20.0%	11	31.4%	1	4.8%
Require Prior Actions Before Appointment	16	5	16.7%	2	5.7%	9	42.9%
Not Accepting Health Plan	8	2	6.7%	5	14.3%	1	4.8%
Not Accepting New Patients	6	1	3.3%	4	11.4%	1	4.8%
Panel Restrictions	4	2	6.7%	1	2.9%	1	4.8%
No Appointments Available	1	0	0.0%	1	2.9%	0	0.0%
Not Providing Services in Nevada*	1	0	0.0%	1	2.9%	0	0.0%
Referral Required	1	0	0.0%	1	2.9%	0	0.0%
Total	**86**	**30**	**100%**	**35**	**100%**	**21**	**100%**

*Phone number provided was for a school-based dental provider no longer contracted with Nevada schools.

Table 4-28 shows the reasons an appointment could not be scheduled with a dental provider. Of the 86 calls where an appointment could not be scheduled, 31 calls resulted in no appointment (36.0 percent) because the dental provider was no longer accepting Medicaid, and callers were unable to reach the appointment scheduling staff in 18 cases (20.9 percent) or needed to take preliminary

actions before being able to schedule (16 cases, 18.6 percent).[19] In general, individual MCOs and FFS performance showed considerable variation in the reasons for not being able to schedule an appointment. AGP exhibited the greatest percentage of calls ending without an appointment and accounted for 40.7 percent of the calls with incomplete appointments, while HPN only had 21 incomplete calls (24.4 percent). Further, FFS calls were most likely to end in a non-appointment due to a dental provider not accepting Medicaid (46.7 percent), but AGP's greatest number of incomplete appointments were associated with callers unable to reach the scheduling staff (31.4 percent), and HPN's non-appointments were primarily due to pre-appointment requirements (42.9 percent).

Table 4-29 describes the minimum, maximum, and average calendar days to an appointment as well as the percentage of calls that met the contractual requirements (i.e., an appointment within 30 calendar days).

Table 4-29—Average Time to Appointment for Dental Providers by FFS and MCOs

MCO/Program	Total Calls	Calls with Appointment		Calendar Days to Appointment			Appointments Within 30 Days[A]	
		Number	Percent	Min	Max	Average	Number	Percent
FFS	96	66	68.8%	0	62	9	63	95.5%
AGP	96	61	63.5%	0	85	15	53	86.9%
HPN	96	75	78.1%	0	49	10	69	92.0%
Total	**288**	**202**	**70.1%**	**0**	**85**	**11**	**185**	**91.6%**

[A] 30 calendar days is the contract standard for appointments for routine dental care.

Overall, of the 288 calls to dental provider offices, 202 calls (70.1 percent) resulted in a dental appointment. On average, appointments with dental providers were scheduled within 11 calendar days, with wait times for an appointment ranging from same-day to 85 days. Variation in appointment wait times was noted among the MCOs and FFS, with FFS exhibiting the lowest average days to an appointment (9 days), followed by HPN (10 days) and AGP (15 days). Of the 202 appointments, 91.6 percent (185 appointments) were scheduled within 30 calendar days in compliance with contract standards. More than 90 percent of the appointments for FFS and HPN were within the contract standard (95.5 percent and 92.0 percent, respectively); however, only 86.9 percent of appointments for AGP met the contract standard.

[19] For outreach calls in which a secret shopper was unable to reach a provider's scheduling staff, callers noted that they were only able to reach voicemail boxes or were placed on hold for more than five minutes. For outreach calls in which a secret shopper was asked to take preliminary action prior to scheduling an appointment, callers may have been requested to designate the provider as their PCP, complete paperwork, or register online with the provider's offices.

5. Conclusions

Overall, the results from the SFY 2014-2015 Provider Network Access Analysis suggest that while the MCOs and FFS have developed comprehensive provider networks, opportunities for improvement exist in the implementation of these networks. In general, the MCOs and FFS have contracted with a large and varied number of providers to ensure Medicaid recipients have access to a broad array of health care services. This is evidenced by the low provider ratios of the MCOs and FFS relative to the general population. Moreover, the location of provider offices is geographically distributed to generally align with the Medicaid recipient population. However, the secret shopper surveys revealed substantial barriers to recipients when trying to schedule appointments. As such, while the network appears robust with regarding the provider infrastructure, access to care is often affected by the ability to schedule appointments.

Provider Capacity

In general, the results from the provider ratio analysis suggest the Medicaid program in Nevada maintains an extensive provider network across the FFS and MCOs for primary care physicians, most specialists, and the majority of facilities. However, the results also highlighted several areas where MCO provider ratios were higher than Nevada's general population. Table 5-1 highlights the specific provider categories where these instances occurred. DHCFP should work with the MCOs to determine, where appropriate, if additional providers in these categories are required to address the needs of the population.

Table 5-1—Provider Types with Ratios Higher than the General Population

MCO	Provider Categories
AGP	◆ Pediatric Mental Health Specialist ◆ Home Health ◆ Psychiatric Inpatient Hospital
HPN	◆ Mental Health Outpatient Services ◆ Home Health ◆ Outpatient Hospital ◆ Psychiatric Inpatient Hospital

Geographic Network Distribution

The results from the geographic network distribution analysis suggests that the Medicaid program in Nevada maintains a geographically accessible provider network across the FFS and MCOs for primary care physicians, most specialists, and majority of facilities in the urban/suburban locations. However, average driving time and distance in rural locations for the FFS population continues to exceed that reported by the general population and the MCOs. Ongoing monitoring by DHCFP and the MCOs is important to maintain and maximize the physician network in rural Nevada.

Appointment Availability

Overall, the results from the secret shopper surveys suggest that while the Medicaid provider network infrastructure is robust, the engagement of providers represents an area for improvement. Across the four categories evaluated in this study (i.e., PCPs, prenatal care providers, specialists, and dentists), close to 50 percent of all outreach calls failed to secure appointments (47.6 percent); and of those calls that ended in an appointment, less than three-quarters (69.4 percent) were scheduled within contract standards. These results indicate the need for ongoing monitoring by DHCFP and the MCOs in order to ensure maximize the physician network in rural Nevada.

Primary Care Providers

Secret shopper survey results for calls to PCPs suggest that appointments for routine primary care are generally available for adults and children once the caller is able to make contact with a valid provider. The most common challenges callers faced when seeking an appointment for an adult included an inability to speak with providers' scheduling staff or providers who were no longer contracted with Medicaid. While appointments were more widely available for children, PCP offices accepting Medicaid and the MCO/Program often requested callers take additional actions prior to appointment scheduling. Further, recipients may be unable to schedule an appointment with the intended provider, especially for providers with an internal medicine subspecialty. Additionally, callers found that a large percentage of primary care appointments offered do not meet Nevada Medicaid contract standards (i.e., two weeks or 14 calendar days), and this was more common among appointments for adults rather than children. These results represent multiple impediments to recipients' access to care, and opportunities for improved access and availability exist regarding the ability to identify a valid PCP currently active with Medicaid and the MCO/Program using existing provider information, the ability to successfully schedule an appointment, and the timeliness of available appointments.

Prenatal Care Providers

First and Second Trimester

Secret shopper results for calls to prenatal care providers suggest Nevada Medicaid recipients in their first or second trimester of pregnancy encounter difficulty in obtaining prenatal care appointments, with a high level of incomplete appointments resulting from challenges in reaching providers' scheduling staff or providers requiring pre-appointment actions by the caller (e.g., pre-appointment screening or pre-registration with the practice). Though the intended provider was available for most successfully scheduled appointments, fewer than half of secret shopper calls resulted in an appointment, and the majority of appointments offered failed to meet Nevada Medicaid contract standards (i.e., seven calendar days). Nearly 60 percent of calls to valid providers did not result in an appointment, indicating that Medicaid recipients may have to call multiple providers to secure an appointment for prenatal care during the first or second trimester.

Third Trimester

Secret shopper results for calls to prenatal care providers suggest Nevada Medicaid recipients in their third trimester of pregnancy encounter difficulty in obtaining prenatal care appointments. A

high level of incomplete appointments resulted from providers requiring pre-appointment screening, providers with panel restrictions (e.g., high risk pregnancies only), or challenges in reaching providers' scheduling staff. Though the intended provider was generally available for successfully scheduled appointments, fewer than 40 percent of secret shopper calls resulted in an appointment, and the majority of appointments offered failed to meet Nevada Medicaid contract standards (i.e., three calendar days). More than 60 percent of calls to valid providers did not result in an appointment, indicating that, regardless of the geographic distribution of providers, prenatal care providers have limited availability for Medicaid recipients in the third trimester of pregnancy, and recipients may have to call multiple providers to secure an appointment for prenatal care during the third trimester.

Specialist Providers

Secret shopper results for calls to specialists suggest Nevada Medicaid recipients encounter difficulty in obtaining appointments with specialists, with a high level of incomplete appointments resulting from challenges in reaching providers' scheduling staff or providers requiring referrals. Though fewer than half of secret shopper calls resulted in an appointment, most appointments offered met Nevada Medicaid contract standards (i.e., 30 calendar days). More than 55 percent of calls to valid providers did not result in an appointment, suggesting that Medicaid recipients may have to call multiple providers to secure an appointment with a specialist.

Dental Providers

Overall, secret shopper survey results for calls to dental providers suggest that appointments for routine dental services are available with a majority of dental providers, and nearly all appointments offered meet Nevada Medicaid contract standards (i.e., 30 calendar days). However, slightly less than one-third of calls to valid providers did not result in an appointment, suggesting that Medicaid recipients may have to call more than one dental provider to secure an appointment. AGP recipients are most likely to experience challenges when attempting to contact a valid dental provider using existing provider information and subsequently securing an appointment for routine dental care in a timely manner.

6. Future Directions

Based on its review of the SFY 2014-2015 Provider Network Adequacy report, the Division of Health Care Financing and Policy (DHCFP) has identified areas for improvement related to future studies and developed a list of "lessons learned" that may be utilized to strengthen future Network Analyses.

Future Network Studies

The following areas have identified as opportunities for improving future provider network studies.

- **Expand the Provider Network Workgroup**–The DHCFP should identify potential Divisions, employees, and other key stakeholders that may contribute to the Network Analysis process. In 2015, the DHCFP Administration, Business Lines Unit, the Division of Public and Behavioral Health, and the Department of Health and Human Services Director's Office participated in bi-weekly workgroups with the contracted External Quality Review Organization (EQRO). Future analyses may include Division of Insurance and the Silver State Health Insurance Exchange. These entities should be aware of network coverage for their programs, such as adequacy standards, access patterns, and capacity issues for the state of Nevada.

- **Define study definitions early within the scope of work to ensure all workgroup participants and the EQRO team have the same understanding of the research question(s)**–terms that should be defined may include, but are not limited to: capacity, access, adequacy, travel time, travel distance, enrolled provider, active provider, appointment timeframes, and provider type standards.

- **Derive study methodology from workgroup priorities**–The workgroup should be responsible for developing the research question(s) and providing the contracted EQRO vendor a scope of work for the project, which will focus the DHCFP's research to specific questions related to the Managed Care Organizations (MCOs) capacity and ability to provide quality services in a timely manner.

- **Evaluate and establish appropriate benchmarks**–Currently, there are no national Medicaid Managed Care network access standards, nor does Nevada have statewide identified access standards for individual health plans. The DHCFP's MCO contracts identify access standards for Primary Care Practitioners (PCPs), PCP extenders, and dentists. Since there are no state or national standards for specialists at this time, Nevada cannot measure against a state or national benchmark. However, the Centers for Medicare and Medicaid Services Proposed Rules to Medicaid Managed Care and CHIP-delivered Managed Care are proposing that states will assess and certify MCO networks by setting threshold standards for a specified set of providers within the medical and behavioral health specialties. In addition, CMS proposes that states will establish time and distance standards for identified provider types. States are encouraged to align these standards amongst Medicaid, Medicare Advantage, and Marketplace Qualified Health Plans. Regulations communicated within the Final Federal Rule should be incorporated in future Network Analyses.

- **Review, identify, and generate improved data sources**—The workgroup is responsible for working with the EQRO to determine the data sources that will be utilized to answer the selected research question(s). Together, a variety of data sources should be identified and the validity of the data sources discussed, resulting in a selection of data sources to be used for the analyses.

  The EQRO can only process clean and complete data. This is often a time consuming effort to obtain. Recipient enrollment data and FFS provider data is provided by the DHCFP, however, MCO provider data is obtained from the MCOs. A separate phone call with each of the MCO data teams is beneficial in relaying to the MCO the exact sources of data that are required from them. Complete data includes provider files from subcontracted vendors; which can be excluded in initial data transfers if not identified to the MCOs as a requirement.

  The DHCFP and each of the MCOs house the provider data within different Management Information Systems. The Medicaid Management Information System utilizes a provider type and specialty category separate and distinct from those of the MCOs. This currently requires the DHCFP and the contracted EQRO vendor to cross-walk all provider data submitted by taxonomy type and classification from the contracted MCOs and Fee-For-Service benefit plans into specific provider categories identified by the DHCFP. This method of alignment is not without fault; however, it is the most valid option for combining provider types across benefit plans without having all plans utilizing the same Management Information Systems and provider type and specialty category structure.

Lessons Learned

Areas that could be discussed in the future include the following:

- Use the provider list supplied to members from the MCOs' websites when conducting a secret shopper survey. If an appointment cannot be made with a specific physician, conduct a follow-up call with the MCO to allow the MCO the opportunity to schedule an appointment on behalf of the member.

- Verify that the contact information contained in the provider data file supplied by the MCOs is consistent with the provider contact information contained in MCO provider directories that are supplied to managed care enrollees.

- Consider provider capacity.

  - Research encounter claims paid.

  - Have MCOs obtain from providers the number of new Medicaid patients accepted on a quarterly basis and report to the DHCFP.

- Incorporate additional breakouts by geographic areas. For example, the *rural* classification should be further disaggregated into *frontier* areas where population density is less than 6 persons per square mile.
- Look to include data sets other than the National Plan and Provider Enumeration System (NPPES) databases, such as licensing boards, the American Medical Association, and other private sources (e.g., Claritas). Additional resources and assistance can be obtained from the Division of Public and Behavioral Health's Primary Care Office.

7. Study Limitations

The following limitations should be considered when reviewing the results of the provider ratio analyses presented in this results brief. Variation in the results may be affected by one or more of these factors.

- The NPPES NPI data file contained all health care providers with an active NPI and license with the State of Nevada. The primary provider taxonomy type, taxonomy classification, and taxonomy specialty fields were used to categorize providers in accordance with the provider categories used for Nevada's Medicaid program. Since the NPPES provider taxonomy types, classifications, and specialties are independent of the Nevada Medicaid provider type and specialty codes, a crosswalk was developed in collaboration with staff from the DHCFP and the University of Nevada, Las Vegas. This crosswalk was used to map NPPES provider data to the provider categories used in this analysis and defined by DHCFP. However, the quality and strength of the crosswalk is dependent upon the quality of the provider taxonomy information contained within the NPPES data file to appropriately map different specialty types.
- Following receipt of the provider data from DHCFP and the MCOs, HSAG performed a preliminary review of the data to identify omissions and discrepancies in the submitted data. In collaboration with DHCFP and the MCOs, providers were reclassified to ensure consistency in the presentation of provider categories across the three entities—i.e., FFS, AGP, and HPN. However, due to differences in contracting and classification of provider types and specialties, differences may still exist in the classification of MCO and FFS providers.
- Lack of specificity and accuracy in the provider specialty data across the MCO and FFS provider data led to a high number of sampled cases requiring replacement during the secret shopper survey. In the case of PCPs, more cases required replacement than were available in the oversample due to inaccurate or non-specific provider specialty data.
- Provider ratios represent high-level, aggregate measures of capacity based on the number of unique providers relative to recipients. This raw count of capacity does not account for the individual status of a provider's panel (i.e., accepting or not accepting new patients) or how active the provider is in the Medicaid program. Further, it is likely that a portion of providers are contracted to provide services for all three entities—i.e., FFS, AGP, and HPN. As such, the provider ratio represents a potential capacity and may not directly reflect the availability of providers at any point in time. This aspect of network adequacy was explored further through the Appointment Availability analysis.
- There are no national provider-to-recipient ratios (provider ratios), time/distance, or appointment availability standards established for Medicaid. In Nevada, the only provider ratio standards that exist for Nevada Medicaid are those that have been defined for the managed care program for PCPs, PCP Extenders, and dentists. Since provider ratio standards are absent for specialists at the state and national level, Nevada Medicaid network adequacy for specialists cannot be measured against a state or national benchmark. For time/distance requirements in Nevada, only one standard exists (for PCPs) while five standards exist for appointment availability for PCPs, prenatal care providers, specialists, and dentists. The lack of national or contractual standards makes monitoring access and availability difficult and limited to relative performance comparisons that may or may not be appropriate.

- Time/distance metrics represent high-level measures of the similarity in geographic distribution of providers relative to recipients. These raw comparative statistics do not account for the individual status of a provider's panel (i.e., accepting or not accepting new patients) at a specific location or how active the provider is in the Medicaid program. As noted earlier, it is also likely that a portion of providers are contracted to provide services for all three entities—i.e., FFS, AGP, and HPN. As such, the time/distance results only highlight the geographic distribution of a provider network and may not directly reflect the availability of providers at given office locations.
- Geographic access analysis results represent high-level, aggregate measures of provider accessibility based on the driving distance and time to the nearest provider. These results do not account for the individual status of a provider's panel (i.e., accepting or not accepting new patients) or how active the provider is in the Medicaid program. Further, it is likely that a portion of providers are contracted to provide services for all three entities—i.e., FFS, AGP, and HPN. As such, the geographic access analysis results represent potential provider accessibility and may not directly reflect the availability of providers at any point in time. This aspect of network adequacy was explored through the Appointment Availability analysis.
- There are no national distance-based access standards or time-based access standards established for Medicaid. The only distance-based access standards that exist for Nevada Medicaid are those that have been defined for the managed care program for PCPs and Physician extenders. Since access standards are absent for specialists at the state and national level, Nevada Medicaid network adequacy for specialists cannot be measured against a state or national benchmark.

Appendix A—Fee-for-Service/Managed Care Organization Provider Category Crosswalk

Table 0-1: Required Provider Categories and Suggested Provider and Specialty Type Codes				
Provider Category	Provider Type		Provider Specialty	
	Code	Description	Code	Description
Primary Care Providers	20	Physician, MD, Osteopath	Null	
			0	No Specialty
			53	Family Practice
			56	General Practice
			60	Internal Medicine
			139	Pediatrics
			129	Obstetrics
			62	Obstetrics/gynecology
			117	Gynecology
			148	Public Health
	17	Special Clinics	180	Rural Health
			181	Federally Qualified Health Center
	*	MCO-defined code	*	Any other MCO-defined specialties that reflect the specialty types listed above where PROVIDER TYPE is '20'; or an MCO indicator identifies the provider as a PCP
				Walk-in Clinic (for HPN only)
PCP Extenders	24	Certified RN Practitioner	0	No Specialty
			23	Family Nurse Practitioner
			Null	
	74	Nurse Midwife	0	No Specialty
			Null	
	77	Physician Assistant	0	No Specialty
			Null	
	*	MCO-defined code	*	Any other MCO-defined specialties that reflect PROVIDER TYPE = '24', '74', or '77'; or an MCO-defined indicator identifies the provider as a PCP Extender
Allergists	20	Physician, MD, Osteopath	103	Allergy
	*	MCO-defined code	*	Any other MCO-defined specialties that identify an allergy specialist; or MCO-defined indicator identifies the provider as an Allergy specialty provider

Table 0-1: Required Provider Categories and Suggested Provider and Specialty Type Codes				
Provider Category	Provider Type		Provider Specialty	
	Code	Description	Code	Description
Anesthesiologists	20	Physician, MD, Osteopath	57	Anesthesiology
	57		Null	Anesthesiology (for AGP and HPN only)
	72	Nurse Anesthetist	0	No Specialty
			Null	
Cardiology	20	Physician, MD, Osteopath	74	Thoracic Surgery
			106	Cardiovascular
			107	Cardiovascular Surgery
			157	Vascular Surgery
Dentists	20	Physician, MD, Osteopath	170	Maxillofacial Surgery
	22	Dentist	Null	
			0	No specialty
			78	General Dentistry
			79	Orthodontist
			80	Oral Surgery
			81	Periodontics
			164	Emergency Dentist
			165	Family Dentistry
			172	Maxillofacial Prosthetics
			173	Pediatric Dentistry
			175	Prosthodontics
			187	Dental Hygienist
				Endodontist
Dermatology	20	Physician, MD, Osteopath	59	Dermatology
Ear, Nose and Throat	20	Physician, MD, Osteopath	65	Otolaryngology
			123	Laryngology
			132	Otology
			133	Otorhinolaryngology
			159	Rhinology
Endocrinology	20	Physician, MD, Osteopath	110	Diabetes
			112	Endocrinology
Gastroenterology	20	Physician, MD, Osteopath	58	Colon/Rectal Surgery
			114	Gastroenterology
General Surgery	20	Physician, MD, Osteopath	73	General Surgery
Geriatrics	20	Physician, MD, Osteopath	116	Geriatrics
Infectious Disease	20	Physician, MD, Osteopath	122	Infectious Disease

Table 0-1: Required Provider Categories and Suggested Provider and Specialty Type Codes				
Provider Category	Provider Type		Provider Specialty	
	Code	Description	Code	Description
Maternal/Fetal Medicine	20	Physician, MD, Osteopath	67	Neonatology, Pediatrics
			124	Maternal/Fetal Medicine
			145	Perinatal Medicine
Mental Health Outpatient Services	26	Psychologist	Null	
			0	No Specialty
			71	Psy and Neur, Neuropsychologist
			162	Clinical Psychologist
	14	Mental Health, Outpatient	Null	
			0	No Specialty
			300	Limited to when name indicates one of the following professional designations: MD, PhD, LCSW, LMFT, LCPC (AGP only)
			305	Unknown Prov Spec Prov Prov_spec, LCSW
			306	Unknown Prov Spec Prov Prov_spec, LMFT
			307	Unknown Prov Spec Prov Prov_spec, LCPC
	20	Physician, MD, Osteopath	307	Clinical Professional Counselor (for AGP only)
	17	Special Clinics	215	Counseling Services
Nephrology	20	Physician, MD, Osteopath	125	Nephrology
Neurology	20	Physician, MD, Osteopath	61	Neurosurgery
			126	Neurology
OB/GYN	20	Physician, MD, Osteopath	62	Obstetrics/Gynecology
			117	Gynecology
			129	Obstetrics
	74	Nurse Midwife	Null	
			0	No specialty
Oncology/Hematology	20	Physician, MD, Osteopath	108	Chemotherapy
			120	Hematology
			131	Oncology
			150	Radiation Therapy
Orthopedic Medicine	20	Physician, MD, Osteopath	64	Orthopedic Surgery
			153	Sports Medicine
Pathology	20	Physician, MD, Osteopath	66	Pathology
			127	Neuropathology

Table 0-1: Required Provider Categories and Suggested Provider and Specialty Type Codes				
Provider Category	Provider Type		Provider Specialty	
	Code	Description	Code	Description
Pediatric Mental Health Specialist	20	Physician, MD, Osteopath	147	Psychiatry-Child
	26	Psychologist	160	Adolescent Psychology
			161	Child Psychology
Pediatric Physical Health Specialists	20	Physician, MD, Osteopath	135	Pediatric Neurology
			136	Pediatric Intensive Care
			137	Pediatric Ophthalmology
			138	Pediatric Surgery
			140	Pediatric Allergy
			141	Pediatric Cardiology
			142	Pediatric Hematology
			143	Pediatric Oncology
			144	Pediatric Pulmonary
			147	Psychiatry-Child
Psychiatry	20	Physician, MD, Osteopath	113	Forensic Psychiatry
			146	Psychiatry
Pulmonary Medicine	20	Physician, MD, Osteopath	104	Bronchoesophagology
			149	Pulmonary Diseases
			151	Respiratory Diseases
Radiology	20	Physician, MD, Osteopath	72	Radiology
			100	Mammography
			128	Nuclear Medicine
			218	Diagnostic Radiology
Rehabilitation	20	Physician, MD, Osteopath	68	Phys Med/Rehab
			92	Rehabilitation
			130	Occupational Medicine
			134	Pain Management
	34	Therapy	0	No specialty
			27	Physical Therapy
			28	Occupational Therapy
			29	Speech Pathologist
			176	Respiratory Therapist
			219	Speech Pathologist (Language)
			Null	
	76	Audiologist	0	No Specialty
			245	Unknown Prov Spec Prov Prov_sp
			Null	
Rheumatology	20	Physician, MD, Osteopath	121	Immunology
			152	Rheumatology

Table 0-1: Required Provider Categories and Suggested Provider and Specialty Type Codes				
Provider Category	Provider Type		Provider Specialty	
	Code	Description	Code	Description
Urology	20	Physician, MD, Osteopath	156	Urologic Surgery
Vision	20	Physician, MD, Osteopath	63	Ophthalmology
			158	Vitreoretinal Surgery
	25	Optometrist	Null	
			0	No Specialty
	41	Optician, Optical Business	0	No Specialty
Other Surgeries	20	Physician, MD, Osteopath	101	Reconstructive Surgery
			118	Hand Surgery
			119	Head/Neck Surgery
			154	Traumatic Surgery
Facilities/Supplies/Miscellaneous				
Ambulatory Surgical Centers	10	Outpatient Surgery, Hosp Based	Null	
			0	No Specialty
	46	Ambulatory Surgical Centers	Null	
			0	No Specialty
Dialysis/ESRD Facility	45	ESRD Facility	Null	
			0	No Specialty
Home Health	29	Home Health Agency	Null	
			0	No Specialty
Hospice	64	Hospice	0	No Specialty
	65	Hospice, Long Term Care	0	No Specialty
Inpatient Hospital	11	Hospital, Inpatient	Null	
			0	No Specialty
	75	Critical Access Hosp/Inpatient	0	
	*	MCO-defined code	*	Hospital - Tertiary (for HPN only)
Intermediate Care Facility/ID	16	ICF-ID/Public	0	No Specialty
	68	ICF-ID/Private	0	No Specialty
Outpatient Hospital	12	Hospital, Outpatient	Null	
			0	No Specialty
Personal Care Attendants (PCA)	30	Personal Care Aid-Prov Agency	0	No Specialty
	83	Personal Care Aid-Inter Serv Orgn	0	No Specialty
Psychiatric Inpatient Hospital	13	Psychiatric, Inpatient	Null	
			0	No Specialty
	63	Residential Treatment Ctr	0	No Specialty
Rehabilitation	56	Mental Hosp (Rehab/Sp) Inpt [LTC]	Null	
			0	No Specialty

Table 0-1: Required Provider Categories and Suggested Provider and Specialty Type Codes				
Provider Category	Provider Type		Provider Specialty	
	Code	Description	Code	Description
Skilled Nursing Facility	19	Nursing Facility	0	No Specialty
			184	Free Standing
			185	Hospital Based
			186	Veterans Facility
	44	Swing-Bed, Acute Hospital	0	No Specialty

Appendix B—National Plan and Provider Enumeration System Provider Category Crosswalk

Due to the large number of provider taxonomies associated with the NPPES provider, the complete crosswalk can be accessed through the icon below.

Link:
NPPES Taxonomy Crosswalk

Telephone Survey Script

1. Determine whether the doctor you are calling is a PCP or Specialist, Dentist, or Prenatal Care provider. Based on the answer, please follow the script accordingly. If a Prenatal Care provider, determine if the sample case has been designated as a 1st/2nd Trimester patient or 3rd Trimester patient.

2. Call the office and write down the name of the person you are speaking to.

3. **If a PCP or Specialist provider:** "Hello, my name is ________. I have just moved into the area, and I am looking for a new doctor. I have health insurance through Medicaid [and am enrolled with______________].[20] Is Dr. _________ taking new patients?" (If YES, then SKIP TO Question #9; if NO, then SKIP TO Question #7.)

4. **If a Dentist:** "Hello, my name is ________. I have just moved into the area, and I am looking for a new dentist for my son. He has insurance through Medicaid [and is enrolled with______________].[6] Is Dr. _________ taking new patients?" (If YES, then SKIP TO Question #9; if NO, then SKIP TO Question #7.)

5. **If a prenatal care doctor (for 1st/2nd trimester patients):** "Hello, my name is ________. I have just moved into the area and am looking for a new OB doctor; I have insurance through Medicaid [and am enrolled with ________________].[6] I'm 20 weeks pregnant and am wondering if Dr. _________ is taking new patients?" (If YES, then SKIP TO Question #9; if NO, then SKIP TO Question #7.)

6. **If a prenatal care doctor (for 3rd trimester patients):** "Hello, my name is ________. I have just moved into the area and am looking for a new OB doctor; I have insurance through Medicaid [and am enrolled with ________________].[6] I'm 36 weeks pregnant and am wondering if Dr. _________ is taking new patients?" (If YES, then SKIP TO Question #9; if NO, then SKIP TO Question #7.)

7. "Are there any other doctors [dentists][7] in your office taking new patients?" (If YES, then SKIP TO Question #8; if NO, then SKIP TO Question #12.)

8. "What is the name of the doctor [dentist][21]? ______________________

[20] Bracketed "[]' text will only be used for recipients enrolled with an MCO.
[21] For dentists, "doctor" will be replaced with "dentist".

9. How soon can I get an appointment scheduled? (If non-PCP provider, then SKIP TO Question #12; if PCP provider, the SKIP TO Question #10.)

10. "I have kids, does Dr. __________ see kids?" (If YES, then SKIP TO Question #11; if NO, then SKIP TO Question #12.)

11. "How soon can I get my son an appointment with Dr. _____________?

12. "Thank you. I will call back later".

Clinical Scenarios by Provider Specialty

Sample Group	Provider Category	Provider Specialty	Clinical Scenarios
PCP	PCP Extenders	Family Nurse Practitioner	Establish self (child) as a patient; annual check-up or (well-child visit).
		No Spec Code	
		No Specialty	
	Primary Care Providers	Family Practice	Establish self (child) as a patient; annual check-up or (well-child visit).
		Federally Qualified Health Center	
		General Practice	
		Internal Medicine	
		No Spec Code	
		No Specialty	
		Pediatrics	
		Rural Health	
OB/GYN	OB/GYN	Gynecology	Establish self as patient; annual well-woman exam.
		No Spec Code	Establish self as patient; annual well-woman exam.
		No specialty	Establish self as patient; annual well-woman exam.
		Obstetrics	Positive pregnancy test and need to establish prenatal care.
		Obstetrics/Gynecology	Positive pregnancy test and need to establish prenatal care.

Sample Group	Provider Category	Provider Specialty	Clinical Scenarios
Specialists	Allergists	Allergy	Sneezing and burning eyes.
	Cardiology	Cardiovascular	Seeking 2nd opinion regarding recommendation for cardiac catheterization (a medical procedure used to help diagnose heart conditions).
		Cardiovascular Surgery	Seeking 2nd opinion regarding recommended heart valve repair. Will forward previous medical record.
		Thoracic Surgery	Seeking 2nd opinion regarding a recommended heart valve repair. Will forward previous medical record.
		Vascular Surgery	Seeking surgery to repair varicose veins.
	Dermatology	Dermatology	Rash.
	Ear, Nose and Throat	Otolaryngology	Adult or children possessing chronic ear infections.
		Otorhinolaryngology	Recurring sinus infections; PCP recommended seeing a specialist.
	Endocrinology	Endocrinology	Diabetic.
	Gastroenterology	Colon/Rectal Surgery	Need a colonoscopy.
		Gastroenterology	Stomach pain after eating.
	General Surgery	General Surgery	Hiatal hernia.
	Geriatrics	Geriatrics	Need a new physician for my 62 year old mother who is showing signs of dementia.
	Infectious Disease	Infectious Disease	Sore on leg hasn't healed with steroid creams or antibiotics; PCP suggested I see a specialist.
	Maternal/Fetal Medicine	Neonatology, Pediatrics	Seeking new provider for 4 month old baby born at 33 weeks.
		Perinatal Medicine	During my first pregnancy I became diabetic. A year ago, I delivered a stillborn baby and I am pregnant again. My PCP advised I see a Perinatologist if I ever get pregnant again.

Sample Group	Provider Category	Provider Specialty	Clinical Scenarios
Specialists	Mental Health Outpatient Services	Clinical Psychologist	PCP recommended psychologist for depression.
		Counseling Services	Going through a divorce, seeking counseling services.
		No Spec Code	PCP recommended treatment for depression.
		No Specialty	PCP recommended treatment for depression.
		Psychology/Neurology, Neuropsychologist	Biofeedback, PCP recommended treatment for depression.
		Unknown Prov Spec Prov Prov_spec, LCPC	(1) Seeking counseling for ADD symptoms – difficulty concentrating and staying on task; procrastinating; getting depressed and anxious when deadlines missed. (2) Going through a divorce, seeking counseling services.
		Unknown Prov Spec Prov Prov_spec, LCSW	(1) Seeking counseling for ADD symptoms – difficulty concentrating and staying on task; procrastinating; getting depressed and anxious when deadlines missed. (2) Going through a divorce, seeking counseling services.
		Unknown Prov Spec Prov Prov_spec, LMFT	(1) Seeking counseling for ADD symptoms – difficulty concentrating and staying on task; procrastinating; getting depressed and anxious when deadlines missed. (2) Going through a divorce, seeking counseling services.
	Nephrology	Nephrology	I have had 4 kidney stones and want to see how they can be prevented.
	Neurology	Neurology	I had a seizure and my family doctor wants me to see a neurologist.
		Neurosurgery	Told I should have lumbar spinal fusion for persistent back pain.
	Oncology/Hematology	Hematology	I have chronic anemia and show no signs of improvement.
		Oncology	I have leukemia.
		Radiation Therapy	I had DCIS, Ductal Carcinoma In-Situ (*meaning in one spot*), treated by lumpectomy 6 weeks ago. No lymph node involvement, no chemotherapy, and surgical site healed. An oncologist wants me to consider radiation.

Sample Group	Provider Category	Provider Specialty	Clinical Scenarios
Specialists	Orthopedic Medicine	Orthopedic Surgery	I have a broken ankle per urgent care. *Note: surgeons are generally specialized (e.g., feet, knees, etc.), if the provider indicates other specialty, then call back and modify based on that specialty.*
	Other Surgeries	Hand Surgery	I have a broken wrist per urgent care.
	Pediatric Mental Health Specialist	Child Psychology	My 6 year old child has tantrums.
		Psychiatry-Child	My 6 year old is becoming increasingly aggressive and difficult to handle. Issues in school and home.
	Pediatric Physical Health Specialists	Pediatric Cardiology	My 6 month old was diagnosed with a ventricular septal defect and I need to find a specialist for possible repair.
		Pediatric Hematology	My 3 year old child is anemic per our pediatrician.
		Pediatric Intensive Care	Hospitalists told me my 3 year old child has a spinal defect and will need surgery.
		Pediatric Neurology	My 8 year old is having migraine headaches.
		Pediatric Oncology	My child has leukemia.
		Pediatric Pulmonary	My 10 year old's asthma is worsening.
		Pediatric Surgery	Pediatrician recommended umbilical hernia repair for my 3 year old.
	Psychiatry	Psychiatry	I am depressed.
	Pulmonary Medicine	Pulmonary Diseases	I have a COPD or Emphysema.
	Rehabilitation	No Spec Code	I had knee surgery and need follow up care.
		No specialty	Need rehab services after hip replacement.
		Occupational Therapy	I had hand surgery and my doctor wants me to see an OT.
		Pain Management	I have chronic back pain.
		Phys Med/Rehab	Seeking care for spouse after a heart attack.
		Physical Therapy	Seeking care for back and leg pain after bike accident.
		Speech Pathologist	Seeking care for 7 year old child's speech impediment – significant lisp and stutter.
		Speech Pathologist (Language)	Seeking care for spouse after a stroke.
		Unknown Prov Spec Prov Prov_sp	Seeking care for spouse after a heart attack.

Sample Group	Provider Category	Provider Specialty	Clinical Scenarios
Specialist	Rheumatology	Immunology	MD told me I have lupus and should find a specialist. Symptoms include raised rash on arms and chest; joint pain; finger and toe spasms during recent flu. MD did blood work.
		Rheumatology	My joints hurt and swell.
	Urology	Urologic Surgery	I keep wetting my pants.
	Vision	No Spec Code	Establish self as patient; annual vision exam; headaches and blurred vision.
		No Specialty	Establish self as patient; annual vision exam; headaches and blurred vision.
		Ophthalmology	(1) PCP recommended specialist for a bump inside eye. (2) For retinal specialists, diagnosed with diabetes and doctor recommended seeing a retinal specialist since mother was diabetic and lost her eyesight due to diabetes.
Dentists	Dentists	Dental Hygienist	Set up routine care, annual cleaning or check-up.
		Endodontist / No Specialty	Dentist recommended seeing specialist for a root canal.
		Family Dentistry	Set up routine care, annual cleaning or check-up.
		General Dentistry	Set up routine care, annual cleaning or check-up.
		No specialty	Set up routine care, annual cleaning or check-up.
		Oral Surgery	Dentist recommended oral surgeon to extract wisdom tooth.
		Orthodontist	Correction of an overbite or crooked teeth (affecting bite); for child, permanent teeth coming in crooked.
		Pediatric Dentistry	For a 4 year old, set up routine care, annual cleaning or check-up.
		Periodontics	Dentist recommended seeing a periodontist for receding and bleeding gums.

Appendix D—Appointment Availability Detail Results

Detailed Primary Care Provider Results

Table 0-1—Reason for Replacement of PCPs for Invalid Contacts							
		FFS		AGP		HPN	
Reasons for Replacement	Total	Number	Percent	Number	Percent	Number	Percent
Exclusion*	106	40	37.7%	33	31.1%	33	31.1%
Incorrect Specialty	14	4	28.6%	5	35.7%	5	35.7%
Incorrect/Bad Telephone Number	3	1	33.3%	1	33.3%	1	33.3%
Other	2	0	0.0%	0	0.0%	2	100.0%
Total	**125**	**45**	**36.0%**	**39**	**31.2%**	**41**	**32.8%**

*Includes hospitalists, senior care facility physicians, and emergency room physicians.

Table 0-2—Percent of Confirmed Appointments for Intended Versus Alternate* PCPs Taking Appointments for Adults by Specialty and MCO/Program										
		FFS			AGP			HPN		
Provider Specialty	Calls with Appt.	Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider
PCP Extenders - Family Nurse Practitioner	10	10	70.0%	30.0%	0	N/A	N/A	0	N/A	N/A
PCP Extenders - No Specialty Code**	6	0	N/A	N/A	6	50.0%	50.0%	0	N/A	N/A
PCP Extenders - No Specialty***	19	2	100%	0.0%	8	87.5%	12.5%	9	44.4%	55.6%
Primary Care Providers - Family Practice	37	12	75.0%	25.0%	12	58.3%	41.7%	13	46.2%	53.8%
Primary Care Providers - Federally Qualified Health Center	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A
Primary Care Providers - General Practice	2	1	100%	0.0%	1	100%	0.0%	0	N/A	N/A
Primary Care Providers - Internal Medicine	15	6	33.3%	66.7%	6	33.3%	66.7%	3	66.7%	33.3%
Primary Care Providers - No Specialty***	3	3	100%	0.0%	0	N/A	N/A	0	N/A	N/A
Total****	**93**	**35**	**71.4%**	**28.6%**	**33**	**60.6%**	**39.4%**	**25**	**48.0%**	**52.0%**

*"Intended" refers to cases in which an appointment was scheduled with the provider that was randomly selected for the secret shopper outreach calls. "Alternate" refers to cases in which an appointment was scheduled but not with the "Intended" provider.
** Refers to PCP Extenders with no specialty code.
*** Refers to PCP Extenders or PCPs with a specialty code of "000" in the provider files.
****Does not include outreach calls to pediatricians; Pediatric results are displayed in Tables 0-6 through 0-9.

Table 0-3—Average Time to Appointment for PCPs Taking Appointments for Adults Enrolled with AGP by Specialty

Provider Specialty	Total Calls*	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
PCP Extenders - No Specialty Code**	13	6	46.2%	1	80	29	4	66.7%
PCP Extenders - No Specialty***	10	8	80.0%	1	52	18	4	50.0%
Primary Care Providers - Family Practice	16	12	75.0%	5	74	29	4	33.3%
Primary Care Providers - General Practice	1	1	100%	61	61	61	0	0.0%
Primary Care Providers - Internal Medicine	12	6	50.0%	7	70	31	1	16.7%
Total*	**52**	**33**	**63.5%**	**1**	**80**	**28**	**13**	**39.4%**

*Does not include outreach calls to pediatricians; Pediatric results are displayed in Tables 0-6 through 0-9.
** Refers to PCP Extenders with no specialty code.
*** Refers to PCP Extenders with a specialty code of "000" in the provider files.

Table 0-4—Average Time to Appointment for PCPs Taking Appointments for Adults Enrolled with HPN by Specialty

Provider Specialty	Total Calls*	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
PCP Extenders - No Specialty**	17	9	52.9%	3	34	16	5	55.6%
Primary Care Providers - Family Practice	23	13	56.5%	2	116	30	7	53.8%
Primary Care Providers - Internal Medicine	16	3	18.8%	16	33	23	0	0.0%
Total*	**56**	**25**	**44.6%**	**2**	**116**	**24**	**12**	**48.0%**

*Does not include outreach calls to pediatricians; Pediatric results are displayed in Tables 0-6 through 0-9.
** Refers to PCP Extenders with a specialty code of "000" in the provider files.

Table 0-5—Average Time to Appointment for PCPs Taking Appointments for Adults Enrolled with FFS by Specialty									
Provider Specialty	Total Calls*	Calls with Appointment		Days to Appointment			Appointments in Compliance		
		Number	Percent	Min	Max	Average	Number	Percent
PCP Extenders - Family Nurse Practitioner	17	10	58.8%	0	40	7	9	90.0%
PCP Extenders - No Specialty**	4	2	50.0%	4	7	6	2	100%
Primary Care Providers - Family Practice	16	12	75.0%	1	74	29	4	33.3%
Primary Care Providers - Federally Qualified Health Center	1	1	100%	0	0	0	1	100%
Primary Care Providers - General Practice	2	1	50.0%	21	21	21	0	0.0%
Primary Care Providers - Internal Medicine	12	6	50.0%	5	50	22	3	50.0%
Primary Care Providers - No Specialty	4	3	75.0%	0	28	10	2	66.7%
Total*	**56**	**35**	**62.5%**	**0**	**74**	**17**	**21**	**60.0%**

*Does not include outreach calls to pediatricians; Pediatric results are displayed in Tables 0-6 through 0-9.
** Refers to PCP Extenders or PCPs with a specialty code of "000" in the provider files.

Table 0-6—Percent of Confirmed Appointments for Intended Versus Alternate* PCPs Taking Appointments for Children by Specialty and MCO/Program										
Provider Specialty	Calls with Appt.	FFS			AGP			HPN		
		Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider
PCP Extenders - Family Nurse Practitioner	8	8	75.0%	25.0%	0	N/A	N/A	0	N/A	N/A
PCP Extenders - No Specialty Code**	4	0	N/A	N/A	4	75.0%	25.0%	0	N/A	N/A
PCP Extenders - No Specialty***	12	2	100%	0.0%	4	100%	0.0%	6	33.3%	66.7%
Primary Care Providers - Family Practice	27	6	66.7%	33.3%	9	66.7%	33.3%	12	41.7%	58.3%
Primary Care Providers - Federally Qualified Health Center	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A
Primary Care Providers - General Practice	1	0	N/A	N/A	1	100%	0.0%	0	N/A	N/A
Primary Care Providers -	4	2	50.0%	50.0%	1	0.0%	100%	1	100.0%	0.0%

Table 0-6—Percent of Confirmed Appointments for Intended Versus Alternate* PCPs Taking Appointments for Children by Specialty and MCO/Program

Provider Specialty	Calls with Appt.	FFS			AGP			HPN		
		Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider
Internal Medicine										
Primary Care Providers - No Specialty***	2	2	100%	0.0%	0	N/A	N/A	0	N/A	N/A
Primary Care Providers - Pediatrics	30	5	60.0%	40.0%	14	71.4%	28.6%	11	72.7%	27.3%
Total	**89**	**26**	**73.1%**	**26.9%**	**33**	**72.7%**	**27.3%**	**30**	**53.3%**	**46.7%**

* "Intended" refers to cases in which an appointment was scheduled with the provider that was randomly selected for the secret shopper outreach calls. "Alternate" refers to cases in which an appointment was scheduled but not with the "Intended" provider.
** Refers to PCP Extenders with no specialty code.
*** Refers to PCP Extenders or PCPs with a specialty code of "000" in the provider files.

Table 0-7—Average Time to Appointment for PCPs Taking Appointments for Children Enrolled with AGP by Specialty

Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
PCP Extenders - No Specialty Code*	6	4	66.7%	1	80	23	3	75.0%
PCP Extenders - No Specialty**	5	4	80.0%	1	52	24	2	50.0%
Primary Care Providers - Family Practice	9	9	100%	5	74	29	3	33.3%
Primary Care Providers - General Practice	1	1	100%	61	61	61	0	0.0%
Primary Care Providers - Internal Medicine	1	1	100%	29	29	29	0	0.0%
Primary Care Providers – Pediatrics	21	14	66.7%	0	40	9	11	78.6%
Total	**43**	**33**	**76.7%**	**0**	**80**	**20**	**19**	**57.6%**

* Refers to PCP Extenders with no specialty code.
** Refers to PCP Extenders with a specialty code of "000" in the provider files

Table 0-8—Average Time to Appointment for PCPs Taking Appointments for Children Enrolled with HPN by Specialty								
Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
PCP Extenders - No Specialty*	6	6	100.0%	4	34	18	3	50.0%
Primary Care Providers - Family Practice	15	12	80.0%	2	117	29	7	58.3%
Primary Care Providers - Internal Medicine	2	1	50.0%	20	20	20	0	0.0%
Primary Care Providers – Pediatrics	13	11	84.6%	0	11	5	11	100.0%
Total**	**36**	**30**	**83.3%**	**0**	**117**	**18**	**21**	**70.0%**

* Refers to PCP Extenders with a specialty code of "000" in the provider files

Table 0-9—Average Time to Appointment for PCPs Taking Appointments for Children Enrolled with FFS by Specialty								
Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
PCP Extenders - Family Nurse Practitioner	8	8	100%	0	40	7	7	87.5%
PCP Extenders - No Specialty*	2	2	100%	4	14	9	2	100%
Primary Care Providers - Family Practice	6	6	100%	2	35	17	3	50.0%
Primary Care Providers - Federally Qualified Health Center	1	1	100%	0	0	0	1	100%
Primary Care Providers - Internal Medicine	3	2	66.7%	5	6	6	2	100%
Primary Care Providers - No Specialty*	2	2	100%	0	1	1	2	100%
Primary Care Providers – Pediatrics	10	5	50.0%	1	14	8	5	100%
Total	**32**	**26**	**81.3%**	**0**	**40**	**9**	**22**	**84.6%**

* Refers to PCP Extenders and PCPs with a specialty code of "000" in the provider files

Detailed Prenatal Care Results

First and Second Trimester

Table 0-10—Overall Telephone Outreach Outcomes for OB/GYN Providers by FFS and MCO for First and Second Trimester Prenatal Care

MCO/Program	Original Sample	Total Calls	Replaced Cases		Final Sample
			Number	Percent	
FFS	48	57	9	18.8%	48
AGP	48	51	3	6.3%	48
HPN	48	51	3	6.3%	48
Total	**144**	**159**	**15**	**10.4%**	**144**

Table 0-11—Reason for Replacement of OB/GYN Providers for Invalid Contacts for First and Second Trimester Prenatal Care

Reason for Replacement	Total	FFS		AGP		HPN	
		Number	Percent	Number	Percent	Number	Percent
Exclusions*	1	0	0.0%	1	100%	0	0.0%
Incorrect/Bad Telephone Number	7	4	57.1%	2	28.6%	1	14.3%
Incorrect Specialty	7	5	71.4%	0	0.0%	2	28.6%
Total	**15**	**9**	**60.0%**	**3**	**20.0%**	**3**	**20.0%**

* This is a hospitalist.

Table 0-12—Percent of Confirmed Appointments for Intended Versus Alternate* OB/GYN Providers by Specialty and MCO/Program for First and Second Trimester Prenatal Care

OB/GYN Specialty	Calls with Appt.	FFS			AGP			HPN		
		Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider
No Specialty	2	1	100%	0.0%	0	N/A	N/A	1	100%	0.0%
Obstetrics/ Gynecology	56	15	73.3%	26.7%	22	72.7%	27.3%	19	68.4%	31.6%
Total	**58**	**16**	**75.0%**	**25.0%**	**22**	**72.7%**	**27.3%**	**20**	**70.0%**	**30.0%**

* "Intended" refers to cases in which an appointment was scheduled with the provider that was randomly selected for the secret shopper outreach calls. "Alternate" refers to cases in which an appointment was scheduled but not with the "Intended" provider.

Table 0-13—Average Time to Appointment for OB/GYN Providers Enrolled with AGP by Specialty for First and Second Trimester Prenatal Care									
Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
Obstetrics/Gynecology	45	22	48.9%	2	101	22	9	40.9%
Total*	**45**	**22**	**48.9%**	**2**	**101**	**22**	**9**	**40.9%**

* Total value does not include specialties in which an appointment was not scheduled for any providers.

Table 0-14—Average Time to Appointment for OB/GYN Providers Enrolled with HPN by Specialty for First and Second Trimester Prenatal Care								
Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
No Specialty	1	1	100%	14	14	14	0	0.0%
Obstetrics/Gynecology	47	19	40.4%	0	48	17	4	21.1%
Total	**48**	**20**	**41.7%**	**0**	**48**	**17**	**4**	**20.0%**

Table 0-15—Average Time to Appointment for OB/GYN Providers Enrolled with FFS by Specialty for First and Second Trimester Prenatal Care								
Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
No Specialty	1	1	100%	43	43	43	0	0.0%
Obstetrics/Gynecology	40	15	37.5%	7	40	19	1	6.7%
Total*	**41**	**16**	**39.0%**	**7**	**43**	**20**	**1**	**6.3%**

* Total value does not include specialties in which an appointment was not scheduled for any providers.

Third Trimester

Table 0-16—Reason for Replacement of OB/GYN Providers for Invalid Contacts for Third Trimester Prenatal Care							
Reasons for Replacement	Total	FFS		AGP		HPN	
		Number	Percent	Number	Percent	Number	Percent
Incorrect/Bad Telephone Number	9	6	66.7%	2	22.2%	1	11.1%
Incorrect Specialty	8	3	37.5%	1	12.5%	4	50.0%
Total	**17**	**9**	**52.9%**	**3**	**17.6%**	**5**	**29.4%**

Table 0-17—Percent of Confirmed Appointments for Intended Versus Alternate* OB/GYN Providers by Specialty and MCO/Program for Third Trimester Prenatal Care

Provider Specialty	Calls with Appt.	FFS			AGP			HPN		
		Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider
Gynecology	2	0	N/A	N/A	0	N/A	N/A	2	100.0%	0.0%
No Specialty	1	0	N/A	N/A	1	100.0%	0.0%	0	N/A	N/A
Obstetrics/ Gynecology	51	15	73.3%	26.7%	21	85.7%	14.3%	15	93.3%	6.7%
Total	**54**	**15**	**73.3%**	**26.7%**	**22**	**86.4%**	**13.6%**	**17**	**94.1%**	**5.9%**

* "Intended" refers to cases in which an appointment was scheduled with the provider that was randomly selected for the secret shopper outreach calls. "Alternate" refers to cases in which an appointment was scheduled but not with the "Intended" provider.

Table 0-18—Average Time to Appointment for OB/GYN Providers Enrolled with AGP by Specialty for Third Trimester Prenatal Care

Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
No Specialty	1	1	100.0%	3	3	3	1	100.0%
Obstetrics/Gynecology	44	21	47.7%	0	45	19	3	14.3%
Total*	**45**	**22**	**48.9%**	**0**	**45**	**18**	**4**	**18.2%**

* Total value does not include specialties in which an appointment was not scheduled for any providers.

Table 0-19—Average Time to Appointment for OB/GYN Providers Enrolled with HPN by Specialty for Third Trimester Prenatal Care

Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
Gynecology	3	2	66.7%	6	19	13	0	0.0%
Obstetrics/Gynecology	45	15	33.3%	1	49	15	3	20.0%
Total	**48**	**17**	**35.4%**	**1**	**49**	**15**	**3**	**17.6%**

Table 0-20—Average Time to Appointment for OB/GYN Providers Enrolled with FFS by Specialty for Third Trimester Prenatal Care

Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
Obstetrics/Gynecology	44	15	34.1%	1	50	15	3	20.0%
Total*	**44**	**15**	**34.1%**	**1**	**50**	**15**	**3**	**20.0%**

* Total value does not include specialties in which an appointment was not scheduled for any providers.

Detailed Specialist Results

Table 0-21—Reasons for Replacement of Specialist Providers for Invalid Contacts							
Reasons for Replacement	Total	FFS		AGP		HPN	
		Number	Percent	Number	Percent	Number	Percent
Incorrect/Bad Telephone Number	15	8	53.3%	4	26.7%	3	20.0%
Incorrect Specialty	8	3	37.5%	3	37.5%	2	25.0%
Exclusions*	4	3	75.0%	0	0.0%	1	25.0%
Total	**27**	**14**	**51.9%**	**7**	**25.9%**	**6**	**22.2%**

*Includes Hospitalists.

Table 0-22—Percent of Confirmed Appointments for Intended Versus Alternate* Specialist Providers by Specialty and MCO/Program										
Provider Specialty	Calls with Appt.	FFS			AGP			HPN		
		Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider
Cardiology - Cardiovascular	9	1	100%	0.0%	4	100%	0.0%	4	100%	0.0%
Cardiology - Cardiovascular Surgery	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A
Cardiology - Vascular Surgery	1	0	N/A	N/A	1	100%	0.0%	0	N/A	N/A
Dermatology - Dermatology	3	1	100%	0.0%	1	100%	0.0%	1	100%	0.0%
Ear, Nose and Throat - Otolaryngology	3	0	N/A	N/A	2	100%	0.0%	1	0.0%	100%
Ear, Nose and Throat - Otorhinolaryngology	1	1	0.0%	100%	0	N/A	N/A	0	N/A	N/A
Gastroenterology - Gastroenterology	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A
General Surgery - General Surgery	5	2	50.0%	50.0%	0	N/A	N/A	3	100%	0.0%
Maternal/Fetal Medicine - Neonatology, Pediatrics	1	0	N/A	N/A	0	N/A	N/A	1	0.0%	100%
Mental Health Outpatient Services - Clinical Psychologist	5	1	100%	0.0%	4	100%	0.0%	0	N/A	N/A
Mental Health Outpatient Services - Counseling	1	0	N/A	N/A	0	N/A	N/A	1	100%	0.0%

Table 0-22—Percent of Confirmed Appointments for Intended Versus Alternate* Specialist Providers by Specialty and MCO/Program

Provider Specialty	Calls with Appt.	FFS			AGP			HPN		
		Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider
Services										
Mental Health Outpatient Services - No Specialty	13	13	84.6%	15.4%	0	N/A	N/A	0	N/A	N/A
Mental Health Outpatient Services - Unknown Prov Spec, LCPC	2	1	100%	0.0%	1	100%	0.0%	0	N/A	N/A
Mental Health Outpatient Services - Unknown Prov Spec, LCSW	5	0	N/A	N/A	4	75.0%	25.0%	1	100%	0.0%
Mental Health Outpatient Services - Unknown Prov Spec, LMFT	5	0	N/A	N/A	4	50.0%	50.0%	1	0.0%	100%
Nephrology - Nephrology	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A
Neurology - Neurology	2	0	N/A	N/A	2	50.0%	50.0%	0	N/A	N/A
Orthopedic Medicine - Orthopedic Surgery	1	0	N/A	N/A	1	100%	0.0%	0	N/A	N/A
Other Surgeries - Reconstructive Surgery	1	0	N/A	N/A	0	N/A	N/A	1	0.0%	100%
Pediatric Mental Health Specialist - Psychiatry-Child	1	0	N/A	N/A	1	100%	0.0%	0	N/A	N/A
Pediatric Physical Health Specialists - Pediatric Cardiology	2	0	N/A	N/A	1	100%	0.0%	1	100%	0.0%
Pediatric Physical Health Specialists - Pediatric Surgery	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A
Psychiatry - Psychiatry	4	0	N/A	N/A	1	0.0%	100%	3	33.3%	66.7%
Pulmonary Medicine - Pulmonary Diseases	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A
Rehabilitation - No Specialty Code**	1	0	N/A	N/A	0	N/A	N/A	1	100%	0.0%
Rehabilitation - No Specialty***	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A

Table 0-22—Percent of Confirmed Appointments for Intended Versus Alternate* Specialist Providers by Specialty and MCO/Program										
Provider Specialty	Calls with Appt.	FFS			AGP			HPN		
		Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider
Rehabilitation - Occupational Therapy	4	0	N/A	N/A	3	33.3%	66.7%	1	100%	0.0%
Rehabilitation - Pain Management	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A
Rehabilitation - Phys Med/Rehab	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A
Rehabilitation - Physical Therapy	14	3	0.0%	100%	5	40.0%	60.0%	6	66.7%	33.3%
Rehabilitation - Speech Pathologist	4	2	100%	0.0%	0	N/A	N/A	2	50.0%	50.0%
Rehabilitation - Speech Pathologist (Language)	1	1	0.0%	100%	0	N/A	N/A	0	N/A	N/A
Urology - Urologic Surgery	4	0	N/A	N/A	3	100%	0.0%	1	100%	0.0%
Vision - No Specialty	20	9	77.8%	22.2%	2	100%	0.0%	9	100%	0.0%
Vision - Ophthalmology	4	1	100%	0.0%	1	100%	0.0%	2	100%	0.0%
Total	**125**	**44**	**77.3%**	**22.7%**	**41**	**75.6%**	**24.4%**	**40**	**77.5%**	**22.5%**

* "Intended" refers to cases in which an appointment was scheduled with the provider that was randomly selected for the secret shopper outreach calls. "Alternate" refers to cases in which an appointment was scheduled but not with the "Intended" provider.
** Refers to Rehabilitation providers with no specialty code.
*** Refers to Rehabilitation providers with a specialty code of "000" in the provider files.

Table 0-23—Average Time to Appointment for Specialty Providers Enrolled with AGP by Specialty								
		Calls with Appointment		Days to Appointment			Appointments in Compliance	
Provider Specialty	Total Calls	Number	Percent	Min	Max	Average	Number	Percent
Cardiology - Cardiovascular	7	4	57.1%	5	12	9	4	100%
Cardiology - Vascular Surgery	2	1	50.0%	23	23	23	1	100%
Dermatology - Dermatology	2	1	50.0%	58	58	58	0	0.0%
Ear, Nose and Throat - Otolaryngology	2	2	100%	50	53	52	0	0.0%
Mental Health Outpatient Services - Clinical Psychologist	4	4	100%	10	21	15	4	100%
Mental Health Outpatient Services - Unknown Prov Spec, LCPC	1	1	100%	7	7	7	1	100%
Mental Health Outpatient Services - Unknown Prov Spec, LCSW	10	4	40.0%	1	30	10	4	100%
Mental Health Outpatient Services - Unknown Prov Spec, LMFT	6	4	66.7%	0	8	4	4	100%
Neurology - Neurology	6	2	33.3%	6	6	6	2	100%
Orthopedic Medicine - Orthopedic Surgery	3	1	33.3%	3	3	3	1	100%
Pediatric Mental Health Specialist - Psychiatry-Child	1	1	100%	54	54	54	0	0.0%
Pediatric Physical Health Specialists - Pediatric Cardiology	1	1	100%	20	20	20	1	100%
Psychiatry - Psychiatry	5	1	20.0%	2	2	2	1	100%
Rehabilitation - Occupational Therapy	3	3	100%	8	11	9	3	100%
Rehabilitation - Physical Therapy	6	5	83.3%	6	12	8	5	100%
Urology - Urologic Surgery	5	3	60.0%	19	84	41	2	66.7%
Vision - No Specialty	2	2	100%	0	4	2	2	100%
Vision - Ophthalmology	2	1	50.0%	19	19	19	1	100%
Total*	**68***	**41**	**60.3%***	**0**	**84**	**16**	**36**	**87.8%**

* Total value does not include specialties in which an appointment was not scheduled for any providers.

Table 0-24—Average Time to Appointment for Specialty Providers Enrolled with HPN by Specialty								
Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance	
		Number	Percent	Min	Max	Average	Number	Percent
Cardiology - Cardiovascular	7	4	57.1%	8	26	17	4	100%
Dermatology - Dermatology	2	1	50.0%	107	107	107	0	0.0%
Ear, Nose and Throat - Otolaryngology	3	1	33.3%	3	3	3	1	100%
General Surgery - General Surgery	5	3	60.0%	5	8	7	3	100%
Maternal/Fetal Medicine - Neonatology, Pediatrics	1	1	100%	31	31	31	0	0.0%
Mental Health Outpatient Services - Counseling Services	2	1	50.0%	11	11	11	1	100%
Mental Health Outpatient Services - Unknown Prov Spec, LCSW	7	1	14.3%	68	68	68	0	0.0%
Mental Health Outpatient Services - Unknown Prov Spec, LMFT	2	1	50.0%	7	7	7	1	100%
Other Surgeries - Reconstructive Surgery	1	1	100%	19	19	19	1	100%
Pediatric Physical Health Specialists - Pediatric Cardiology	1	1	100%	49	49	49	0	0.0%
Psychiatry - Psychiatry	4	3	75.0%	0	64	32	1	33.3%
Rehabilitation - No Specialty Code	1	1	100%	32	32	32	0	0.0%
Rehabilitation - Occupational Therapy	2	1	50.0%	8	8	8	1	100%
Rehabilitation - Physical Therapy	9	6	66.7%	3	13	8	6	100%
Rehabilitation - Speech Pathologist	3	2	66.7%	27	64	46	1	50.0%
Urology - Urologic Surgery	3	1	33.3%	22	22	22	1	100%
Vision - No Specialty	10	9	90.0%	1	19	7	9	100%
Vision - Ophthalmology	6	2	33.3%	28	33	31	1	50.0%
Total*	**69***	**40**	**58.0%***	**0**	**107**	**20**	**31**	**77.5%**

* Total value does not include specialties in which an appointment was not scheduled for any providers.

Table 0-25—Average Time to Appointment for Specialty Providers Enrolled with FFS by Specialty									
Provider Specialty	Total Calls	Calls with Appointment		Days to Appointment			Appointments in Compliance		
		Number	Percent	Min	Max	Average	Number	Percent	
Cardiology - Cardiovascular	3	1	33.3%	11	11	11	1	100%	
Cardiology - Cardiovascular Surgery	1	1	100%	28	28	28	1	100%	
Dermatology - Dermatology	1	1	100%	42	42	42	0	0.0%	
Ear, Nose and Throat - Otorhinolaryngology	2	1	50.0%	11	11	11	1	100%	
Gastroenterology - Gastroenterology	1	1	100%	42	42	42	0	0.0%	
General Surgery - General Surgery	2	2	100%	3	7	5	2	100%	
Mental Health Outpatient Services - Clinical Psychologist	2	1	50.0%	10	10	10	1	100%	
Mental Health Outpatient Services - No Specialty	18	13	72.2%	1	13	5	13	100%	
Mental Health Outpatient Services - Unknown Prov Spec, LCPC	1	1	100%	4	4	4	1	100%	
Nephrology - Nephrology	4	1	25.0%	12	12	12	1	100%	
Pediatric Physical Health Specialists - Pediatric Surgery	1	1	100%	14	14	14	1	100%	
Pulmonary Medicine - Pulmonary Diseases	1	1	100%	14	14	14	1	100%	
Rehabilitation - No Specialty	3	1	33.3%	2	2	2	1	100%	
Rehabilitation - Pain Management	1	1	100%	29	29	29	1	100%	
Rehabilitation - Phys Med/Rehab	1	1	100%	27	27	27	1	100%	
Rehabilitation - Physical Therapy	12	3	25.0%	0	10	4	3	100%	
Rehabilitation - Speech Pathologist	7	2	28.6%	10	20	15	2	100%	
Rehabilitation - Speech Pathologist (Language)	2	1	50.0%	7	7	7	1	100%	
Vision - No Specialty	10	9	90.0%	0	16	6	9	100%	
Vision - Ophthalmology	1	1	100%	51	51	51	0	0.0%	
Total*	**74***	**44**	**59.5%***	**0**	**51**	**11**	**41**	**93.2%**	

* Total value does not include specialties in which an appointment was not scheduled for any providers

Detailed Dental Results

Table 0-26—Reasons for Replacement of Dental Providers for Invalid Contacts							
Reasons for Replacement	Total	FFS		AGP		HPN	
		Number	Percent	Number	Percent	Number	Percent
Incorrect/Bad Telephone Number	14	7	50.0%	6	42.9%	1	7.1%
Exclusion*	4	1	25.0%	2	50.0%	1	25.0%
Incorrect Specialty	1	1	100%	0	0.0%	0	0.0%
Total	**19**	**9**	**47.4%**	**8**	**42.1%**	**2**	**10.5%**

*Includes hospitalists and school-based dental programs.

Table 0-27—Percent of Confirmed Appointments for Intended Versus Alternate* Dental Providers by Specialty and MCO/Program										
Dental Specialty	Total Calls with Appt.	FFS			AGP			HPN		
		Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider	Total	Intended Provider	Alternate Provider
Dental Hygienist	4	1	0.0%	100%	3	100%	0.0%	0	N/A	N/A
Family Dentistry	1	1	100%	0.0%	0	N/A	N/A	0	N/A	N/A
General Dentistry	125	27	63.0%	37.0%	42	59.5%	40.5%	56	60.7%	39.3%
No Specialty	31	29	82.8%	17.2%	0	N/A	N/A	2	50.0%	50.0%
Oral Surgery	4	1	100%	0.0%	2	100%	0.0%	1	100%	0.0%
Orthodontist	11	4	100%	0.0%	3	100%	0.0%	4	50.0%	50.0%
Pediatric Dentistry	26	3	66.7%	33.3%	11	63.6%	36.4%	12	58.3%	41.7%
Total	**202**	**66**	**74.2%**	**25.8%**	**61**	**65.6%**	**34.4%**	**75**	**60.0%**	**40.0%**

* "Intended" refers to cases in which an appointment was scheduled with the provider that was randomly selected for the secret shopper outreach calls. "Alternate" refers to cases in which an appointment was scheduled but not with the "Intended" provider.

Table 0-28—Average Time to Appointment for Dental Providers Enrolled with AGP by Specialty								
		Calls with Appointment		Days to Appointment			Appointments in Compliance	
Provider Specialty	Total Calls	Number	Percent	Min	Max	Average	Number	Percent
Dental Hygienist	5	3	60.0%	2	6	3	3	100%
General Dentistry	65	42	64.6%	0	85	15	37	88.1%
Oral Surgery	2	2	100%	12	15	14	2	100%
Orthodontist	5	3	60.0%	9	39	24	2	66.7%
Pediatric Dentistry	13	11	84.6%	1	55	15	9	81.8%
Total*	**90***	**61**	**67.8%***	**0**	**85**	**15**	**53**	**86.9%**

* Total value does not include specialties in which an appointment was not scheduled for any providers.

Table 0-29—Average Time to Appointment for Dental Providers Enrolled with HPN by Specialty								
		Calls with Appointment		Days to Appointment			Appointments in Compliance	
Provider Specialty	Total Calls	Number	Percent	Min	Max	Average	Number	Percent
General Dentistry	70	56	80.0%	0	49	9	52	92.9%
No Specialty	3	2	66.7%	7	28	18	2	100%
Oral Surgery	4	1	25.0%	17	17	17	1	100%
Orthodontist	4	4	100%	2	21	13	4	100%
Pediatric Dentistry	15	12	80.0%	2	42	14	10	83.3%
Total	**96**	**75**	**78.1%**	**0**	**49**	**10**	**69**	**92.0%**

Table 0-30—Average Time to Appointment for Dental Providers Enrolled with FFS by Specialty								
		Calls with Appointment		Days to Appointment			Appointments in Compliance	
Provider Specialty	Total Calls	Number	Percent	Min	Max	Average	Number	Percent
Dental Hygienist	1	1	100%	2	2	2	1	100%
Family Dentistry	1	1	100%	1	1	1	1	100%
General Dentistry	49	27	55.1%	0	62	11	24	88.9%
No Specialty	36	29	80.6%	0	30	9	29	100%
Oral Surgery	1	1	100%	5	5	5	1	100%
Orthodontist	4	4	100%	0	12	7	4	100%
Pediatric Dentistry	3	3	100%	4	6	5	3	100%
Total*	**95***	**66**	**69.5%***	**0**	**62**	**9**	**63**	**95.5%**

* Total value does not include specialties in which an appointment was not scheduled for any providers.

Appendix E—MCO Response

The following responses were received from the MCOs following their review of the report.

Amerigroup

The following feedback related to the Ratio Analysis findings was received on 4/10/15, with minor revisions submitted on 4/13/15.

- Pediatric Mental Health Specialists: Based on the provider mapping methodology provider, Amerigroup reported 10 Pediatric Mental Health Specialists; however, nearly 99% of Amerigroup's behavioral health network offer services for pediatric members from the age range of 00-21. Amerigroup is in the process of securing additional Pediatric Mental Health Specialists.
- Home Health: Amerigroup reported 11 home health providers. Currently, Amerigroup is in the process of contracting with additional home health providers.
- Psychiatric Inpatient Hospital: There are four acute facilities (Valley, North Vista, Desert Springs Hospital, Southern Hills Hospital) that are contracted for behavioral health services however are not pulling in our data as Psychiatric Inpatient Hospitals and not included in the count. There is also a new free standing Mental Health Facility that was only effective as of 12/5/14 which is after the date that the data was pulled for this request. Currently, in addition to the acute facilities and State entities, Amerigroup has contracted with all of the private free standing behavioral health facilities in Clark and Washoe County.

Additional feedback was received on 7/30/15 following production of the full report.

Based on the results of the HSAG Appointment Availability Analysis, Amerigroup recognizes the need for ongoing monitoring in order to ensure appointment access for Amerigroup Medicaid Recipients.

- Amerigroup will continue its own annual access and availability studies and follow up with providers which are not compliant with Appointment Availability Standards and those providers who do not have up-to-date demographic information.
- Amerigroup will continue its own regular secret shopper calls to providers to monitor access and availability.
- Amerigroup's Provider Relations Team will review provider demographics during face to face provider visits to ensure provider demographic information is reviewed and validated by the providers so that members can reach the appropriate scheduling staff.
- Amerigroup has a dedicated liaison for OBGYN providers who will work with these providers in regards to access standards.
- Amerigroup will work with its Dental Vendor, SCION Dental, to monitor Appointment Availability and provider demographics.

- Amerigroup Members are able to call Member Services if they need assistance in finding a provider or scheduling an appointment.

Health Plan of Nevada

The following feedback related to the Ratio Analysis results was submitted to State on 4/9/2015.

- Geriatrics–The aged population is excluded from the Medicaid managed care contract. The fact that HPN has any geriatricians contracted is due to the affiliation with Southwest Medical Associates. There is not a requirement in the Medicaid managed care contract for geriatricians.
- Mental Health Inpatient–The FFS list of contracted inpatient mental health facilities includes out of state facilities. HPN's contracted list includes facilities only in the state of Nevada. We use letters of agreement for out of state facilities. Therefore, it is not equitable to compare FFS to the MCO network. Additionally, of the Nevada based facilities on the FFS list, HPN contracts with all but three facilities. Two of the three are owned by the same entity. HPN has a reason for not including these facilities in our network. Finally, there is not a specific facility to member ratio required by contract.
- Hospice–Hospice is an excluded service from the Medicaid managed care contract. HPN has a contract hospice provider. However, no hospice providers are required by contract.
- Outpatient Hospital Facilities–HPN has 18 outpatient hospitals contracted with 17 being in state facilities.