Division of Health Care Financing and Policy

Nevada Medicaid Managed Care

Validation of Network Adequacy

State Fiscal Year 2024

December 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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Validation Overview

The Nevada Division of Health Care Financing and Policy (DHCFP) contracted with Health Services Advisory Group, Inc. (HSAG), as its external quality review organization (EQRO), to conduct network adequacy validation (NAV) for the managed care organizations (MCOs) and dental benefits administrator (DBA). Title 42 of the Code of Federal Regulations (42 CFR) §438.350(a) requires states that contract with MCOs, prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs) (collectively referred to as "managed care entities [MCEs]") to have a qualified EQRO perform an annual external quality review (EQR) that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries across the continuum of services. HSAG conducted NAV, validating the systems and processes, data sources, methods, and results, according to the Centers for Medicare & Medicaid Services (CMS) EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).[1]

HSAG worked with DHCFP to identify applicable quantitative network adequacy standards by provider and plan type to be validated. Information such as description of network adequacy data and documentation, information flow from the MCEs to the State, prior year NAV reports, and additional supporting information relevant to network adequacy monitoring and validation were obtained from the State and incorporated into all phases of validation activities.

The purpose of NAV is to assess the accuracy of the state-defined network adequacy indicators reported by the MCEs and to evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, systems and processes used, and determine the overall validation rating, which refers to the overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as established by the State.

As the EQRO for DHCFP, HSAG was responsible for conducting the state fiscal year (SFY) 2024 validation of network adequacy indicators, confirming the MCEs' ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the MCEs' and DHCFP's network adequacy monitoring efforts.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Sept 17, 2024.

HSAG completed the following CMS EQR Protocol 4 activities to conduct the NAV:

- **Defined the scope of the validation of quantitative network adequacy standards:** HSAG obtained information from the State (i.e., network adequacy standards, descriptions, and samples of documentation the MCEs submit to the State, a description of the network adequacy information flow, and any prior NAV reports), then worked with the State to identify and define network adequacy indicators and provider categories, and to establish the NAV activities and timeline.
- **Identified data sources for validation:** HSAG worked with the State and MCEs to identify NAV-related data sources and to answer clarifying questions regarding the data sources.
- **Reviewed information systems underlying network adequacy monitoring:** HSAG reviewed any previously completed MCE Information Systems Capabilities Assessments (ISCAs), then assessed processes for collecting network adequacy data that were not addressed in the ISCA, completed a comprehensive NAV ISCA by collecting an updated Information Systems Capabilities Assessment Tool (ISCAT) from each MCE, and interviewed MCE staff members or other personnel involved in production of network adequacy results.
- **Validated network adequacy assessment data, methods, and results:** HSAG used the CMS EQR Protocol 4 Worksheet 4.6 Appendix B to document each MCE's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its networks, and produce accurate results that support the MCE's and State's network adequacy monitoring efforts. When evaluating the MCEs for this validation step, HSAG assessed data reliability, accuracy, timeliness, and completeness; the MCEs' methods to assess network adequacy; and the validity of the network adequacy results the MCEs submitted. HSAG summarized its network adequacy indicator-level validation findings resulting in a *Low Confidence* or *No Confidence* designation in the individual MCE-specific sections of this report.
- **Communicated preliminary findings to each MCE:** HSAG communicated preliminary NAV findings to each MCE that provided findings, preliminary validation ratings, areas of potential concern, and recommendations for improvement. Each MCE was provided the opportunity to correct any preliminary report omissions and/or errors.
- **Submitted the NAV findings to the State in the form of the NAV aggregate report:** HSAG used the state-approved NAV aggregate report template to document the NAV findings and submitted the draft and final NAV aggregate report according to the state-approved timeline.

Table 1 displays the MCEs within the scope of review, review date, and primary MCE contact.

Table 1—List of MCEs in Scope of Review

MCE Name (Short Name)	Date	Primary MCE Contact Name and Title	HSAG Lead Reviewer
Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem)	08/13/2024	Abigail Roa, Compliance Director II	Kerry Wycuff
LIBERTY Dental Plan of Nevada, Inc. (LIBERTY)	08/08/2024	Doug Stewart, Manager, Compliance	Arpi Dharia
Molina Healthcare of Nevada, Inc. (Molina)	08/07/2024	Philip Ramirez, Assistant Vice President, Government Contracts	Kerry Wycuff
SilverSummit Healthplan, Inc. (SilverSummit)	08/12/2024	Sarah Fox, Vice President, Network Development & Contracting	Kerry Wycuff
UnitedHealthcare Health Plan of Nevada Medicaid (UHC HPN)	08/08/2024	Shawna DeRousse, Director of Compliance	Kerry Wycuff

Network Adequacy Standards and Indicators Validated

States that contract with MCEs to provide Medicaid or CHIP services are required to develop quantitative network adequacy standards across a subset of provider categories to set expectations for each contracted MCE's provider networks. States may elect to use a variety of quantitative standards including, but not limited to, minimum provider-to-member ratios, time and distance, percentage of providers accepting new patients, and/or combinations of these quantitative measures. Based on the state-defined network adequacy standards, the State and the EQRO defined the network adequacy indicators, which the EQRO then validated. The indicators are metrics used to assess adherence to the quantitative network adequacy standards required and set forth by the State. DHCFP identified network adequacy indicators to be validated for the reporting period(s) during SFY 2024. Table 2 lists the network adequacy standards, the indicators HSAG validated, and the calculation conducted by the MCOs, and Table 3 lists the network adequacy standards, the indicators HSAG validated, and the calculation conducted by the DBA.

Table 2—MCO Network Adequacy Indicators Validated

Provider-to-Member Ratio Standards Provider Category	Provider-to-Member Ratio
Primary Care Provider (PCP)	1:1,500*
Physician Specialist	1:1,500

Time or Distance Standards Provider Category	Member Criteria	Time or Distance Access Standard to the Nearest Provider
Primary Care Providers (PCP)		
Primary Care, Adults	Adults	15 minutes or 10 miles
OB/GYN	Adult Females	15 minutes or 10 miles
Pediatrician	Children	15 minutes or 10 miles
Physician Specialists		
Endocrinologist	Adults	60 minutes or 40 miles
Endocrinologist, Pediatric	Children	60 minutes or 40 miles
Infectious Disease	Adults	60 minutes or 40 miles
Infectious Disease, Pediatric	Children	60 minutes or 40 miles
Rheumatologist	Adults	60 minutes or 40 miles
Rheumatologist, Pediatric	Children	60 minutes or 40 miles
Oncologist—Medical/Surgical	Adults	45 minutes or 30 miles
Oncologist—Medical/Surgical, Pediatric	Children	45 minutes or 30 miles
Oncologist/Radiologist	Adults	60 minutes or 40 miles
Oncologist/Radiologist, Pediatric	Children	60 minutes or 40 miles
Behavioral Health Providers		
Psychologist	Adults	45 minutes or 30 miles
Psychologist, Pediatric	Children	45 minutes or 30 miles
Psychiatrist	Adults	45 minutes or 30 miles
Board Certified Child and Adolescent Psychiatrist	Children	45 minutes or 30 miles
Qualified Mental Health Professional (QMHP)	Adults	45 minutes or 30 miles
QMHP, Pediatric	Children	45 minutes or 30 miles
Facility-Level Providers		
Hospital, All	Adults	45 minutes or 30 miles
Psychiatric Inpatient Hospital	Adults	45 minutes or 30 miles
Dialysis/End Stage Renal Disease (ESRD) Facility	Adults	45 minutes or 30 miles
Pharmacy	All	15 minutes or 10 miles

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one full-time equivalent (FTE) PCP for every 1,800 members.

Table 3—DBA Network Adequacy Indicators Validated

Provider-to-Member Ratio Standards Provider Category	Provider-to-Member Ratio
Dental Primary Care Provider (PCP)	1:1,500

Time or Distance Standards Provider Category	Member Criteria	Time or Distance Access Standard to the Nearest Provider
Dental Providers		
General Dentist	Adults	30 minutes or 20 miles
Dentist, Pediatric	Children	30 minutes or 20 miles
Endodontist	Adults	60 minutes or 40 miles
Periodontist	Adults	60 minutes or 40 miles
Prosthodontist	Adults	60 minutes or 40 miles
Oral Surgeon	Adults	60 minutes or 40 miles
Dental Hygienist	Adults	60 minutes or 40 miles
Dental Therapist	Adults	60 minutes or 40 miles

Description of Validation Activities

Pre-Validation Strategy

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

HSAG prepared a document request packet that was submitted to each MCE outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess each MCE's information systems and processes, network adequacy indicator methodology, and accuracy in network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCEs to identify all data sources informing calculation and reporting at the network adequacy indicator level. Data and documentation from the MCEs such as, but not limited to, network data files or directories and member enrollment files, were obtained through a single documentation request packet provided to each MCE.

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

Validation activities were conducted via interactive virtual review and are referred to as a "virtual review," as the activities are the same in a virtual format as in an on-site format.

Validation Team

The HSAG validation team was composed of lead reviewer(s) and validation team members. HSAG assembled the team based on the skills required for NAV and requirements established by the State. Team members, including the lead reviewer, participated in the virtual review meetings; other validation team members participated in the desk review of submitted documentation only. A full list of validation team members, their roles, and their skills and expertise are provided in Appendix A.

Technical Methods of Data Collection and Analysis

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

- **Information systems underlying network adequacy monitoring:** HSAG conducted an ISCA using each MCE's completed ISCAT and relevant supplemental documentation to understand the processes for maintaining and updating provider data, including how the MCE tracks providers over time, across multiple office locations, and through changes in participation in the MCE's network. The ISCAT was used to assess the ability of the MCE's information systems to collect and report accurate data related to each network adequacy indicator. To do so, HSAG sought to understand the MCE's information technology (IT) system architecture, file structure, information flow, data processing procedures, and completeness and accuracy of data related to current provider networks. HSAG thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Validate network adequacy logic for calculation of network adequacy indicators:** HSAG required each MCE that calculated the state-defined network adequacy indicators to submit documented code, logic, or manual workflows for each indicator in the scope of the validation. HSAG completed a line-by-line review of the logic provided to ensure compliance with the state-defined indicator specifications. HSAG identified whether the required variables were in alignment with the state-defined indicators used to produce the MCE's indicator calculations. HSAG required each MCE that did not use computer programming language to calculate the performance indicators to submit documentation describing the steps the MCE took for indicator calculation.
- **Validate network adequacy data and methods:** HSAG assessed data and documentation from the MCEs that included, but was not limited to, network data files or directories, member enrollment data files, claims and encounter data files (if applicable), member experience survey results, and/or provider and member handbooks. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness.
- **Validate network adequacy results:** HSAG assessed the MCE's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCE and State network adequacy monitoring results. HSAG validated network adequacy reporting against state-defined indicators and against the

most recent network adequacy reports to assess trending patterns and reasonability of reported indicator-level results, if available. HSAG assessed whether the results were valid, accurate, and reliable, and if the MCE's interpretation of the data was accurate.

- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Virtual Review Validation Activities

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

- Opening meeting
- Review of ISCAT and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

HSAG conducted interviews with key MCE staff members who were involved with the calculation and reporting of network adequacy indicators. Appendix A lists the MCEs' interviewees.

Opening meeting: The opening meeting included an introduction of the validation team and key MCE staff members involved in the NAV activities, the review purpose, the required documentation, basic meeting logistics, and organization overview.

Review of the ISCAT and supporting documentation: This session was designed to be interactive with key MCE staff members so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT, and understand systems and processes for maintaining and updating provider data and assessing the MCE's information systems required for NAV. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and verified source data and processes used to inform data reliability and validity of network adequacy reporting.

Evaluation of underlying systems and processes: HSAG evaluated the MCE's information systems, focusing on the MCE's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; MCE oversight of external information systems, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data. Throughout the evaluation, HSAG conducted interviews with key MCE staff members familiar with the

processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff members included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors, and other front-line staff members familiar with network adequacy monitoring and reporting activities.

Overview of data collection, integration, methods, and control procedures: The overview included discussion and observation of methods and logic used to calculate each network adequacy indicator. HSAG evaluated the integration and validation process across all source data and how the analytics files were produced to inform network adequacy monitoring and calculation at the indicator level. HSAG also addressed control and security procedures during this session.

Network adequacy source data PSV and results: HSAG performed additional validation using PSV to further validate the accuracy and integrity of the source data files used to inform network adequacy monitoring and reporting at the indicator level. PSV is a review technique used to confirm that the information from the primary source information systems matches the analytic output files used for reporting. Using this technique, HSAG assessed the methods, logic, and processes used to confirm accuracy of the data and detect errors. HSAG selected key data elements within each source data output file to confirm that the primary source system maintained by the MCE or obtained through external entities matched. For example, the PSV review may detect programming logic errors resulting in further root cause analysis and corrections. HSAG reviewed indicator-level results and assessed alignment with state-defined requirements.

Closing conference: The closing conference included a summation of preliminary findings based on the review of the underlying systems and processes, data collection, integration, and methods used. In addition, findings from the virtual review and documentation requirements for any post-virtual review activities were shared with the MCEs.

Network Adequacy Indicator Validation Rating Determinations

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

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

Table 4—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements

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

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table 5, and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5—Indicator-Level Validation Rating Designations

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

Table 6 and Table 7 present example validation rating determinations. Table 6 presents an example of a validation rating determination that is based solely on the validation score, as there were no *Not Met* elements that were determined to have significant bias on the results, whereas Table 7, presents an example of a validation rating determination that includes a *Not Met* element that had significant bias on the results.

Table 6—Example Validation Rating Determination

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

Table 7—Example Validation Rating Determination

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

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

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

Validation Results

Anthem Blue Cross and Blue Shield Healthcare Solutions

ISCA Findings and Data Validity

HSAG completed an ISCA for **Anthem** and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

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

- **Anthem** used its core system platform, Facets, to maintain comprehensive demographic and eligibility information for its members.
- **Anthem** used Strategic Provider System (SPS) as its provider network management database system.
- Data were extracted from a Microsoft SQL Server for calculating and reporting on network adequacy for the provider network.
- **Anthem** used Quest Analytics software to calculate the required GeoAccess standards used to determine compliance with time or distance standards.

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

- The Application Management and Information Management and Operations Support departments reported having 454 programmers that maintained and supported the applications used by the organization.
- Programming staff members had between 7 to 10 years of data analytics experience.

HSAG identified no concerns with **Anthem**'s information systems data processing procedures and personnel.

Enrollment System

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

- **Anthem** maintained enrollment and eligibility data for Medicaid members within the Facets system.

- **Anthem** received daily enrollment files in the 834 file format from DHCFP that were processed within 24 hours of receipt. **Anthem** received a monthly full 834 file from DHCFP that was used for reconciliation and was processed within two to three business days.
- **Anthem** performed monthly reconciliation between the Facets system and DHCFP's data to ensure completeness and accuracy of enrollment data.
- Facets maintained a transaction history for each occurrence of additions, modifications, terminations, date spans, and reinstatements through the audit and security files.
- **Anthem**'s reconciliation and oversight of enrollment data included the following:
  - The 834 file load process provided reports that identified errors encountered, counted the transactions processed, and provided a complete audit trail of the update process.
  - **Anthem** conducted compliance review to ensure all required member data element fields were included. If any deficiencies or discrepancies were identified, **Anthem** requested a corrected 834 file from Gainwell Technology, DHCFP's vendor, or DHCFP.
  - Membership on the 834 file was reconciled with membership information in the Facets system by cross referencing the data. Any variances or discrepancies were researched by the Medicaid Enrollment and Billing department, and if unable to be resolved internally by **Anthem**, **Anthem** submitted the issues to DHCFP or their vendor, Gainwell Technology, for verification or resolution.
- **Anthem**'s Facets system captured and maintained both the state-issued Medicaid ID and a Facets-generated Subscriber ID. If the Medicaid ID changed for any reason, **Anthem** used the Facets-generated Subscriber ID to link enrollment history and as its source of truth for network adequacy reporting.
- **Anthem** identified member demographic updates based on the daily and monthly 834 enrollment files.
  - Member's residence was determined within the source system by "address type." A member's physical address, mailing address, and contact address were stored in the source system and loaded from DHCFP Medicaid enrollment files. Enrollment received daily transactions as well as full monthly audit files, and member demographic changes were processed through batch transactions. Source system audit tracking allowed for historical information to be reviewed if needed.

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

Provider Data Systems

HSAG evaluated the information systems and processes used by **Anthem** to capture provider data and identified the following findings:

- **Anthem** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.

- **Anthem** conducted data validation activities for accuracy and completeness in the logic and methodology and consistency in calculation.
- **Anthem** collected data from providers in standardized formats (e.g., credentialing applications), to the extent feasible and appropriate.

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

- **Anthem** maintained provider credentialing data in the SmartCred system. Once provider credentialing was approved, the information was added to the SPS system.
- **Anthem** maintained provider network status data in the SPS system.
- **Anthem** captured DHCFP-required provider categories and specialties by using an internal crosswalk in the SPS system. Providers identified and attested specialties via Availity provider data management (PDM), rosters, and in the credentialing process. These processes provided consistent outcomes and were considered the source of truth.
- **Anthem**'s procedures for updating and maintaining provider data included:
  - Receiving a monthly file from DHCFP that included providers who had completed the Medicaid enrollment process and loading them into tables that included the required DHCFP-assigned provider identification information such as Medicaid excluded providers and organizations.
  - Conducting PSV of provider information using National Plan and Provider Enumeration System (NPPES), applying business rules, addressing standardization, and applying code sets to confirm accuracy of provider data.
- **Anthem** used SPS to track providers over time, across multiple office locations, and through changes in participation in **Anthem**'s network.
- **Anthem** required its provider network to update provider data every 90 days through submission of updated rosters and attesting to their data through **Anthem**'s online provider directory. Additionally, providers were to notify **Anthem** when changes occurred. Providers were made aware of this expectation through contract language and provider newsletters.

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

Delegated Entity Data and Oversight

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

- **Anthem** did not subcontract any network adequacy-related services to delegated entities.

Network Adequacy Indicator Reporting

HSAG's assessment of **Anthem**'s network adequacy indicator reporting processes included the following findings:

- **Anthem** used Quest Analytics software to calculate the required GeoAccess standards used to determine compliance with time or distance standards.
- **Anthem** integrated two data sources for network adequacy indicator reporting: Medicaid member data from the Facets system and provider data from the SPS system.
- **Anthem** maintained data control procedures to ensure accuracy and completeness of data merges from Facets and SPS by extracting the raw data using SQL code from its Operational Data Warehouse (ODW). The ODW data were then imported into Quest Analytics software to conduct GeoAccess analysis.
  - **Anthem** reviewed file sizes to ensure the number of records in each file was accurate and complete.
  - Controls included using SQL code to extract eligible Medicaid members and providers who were active when the report was generated.
  - Both member and provider datasets were given a unique identifier or primary key to prevent duplication.
- **Anthem** used appropriate methodologies to assess adherence to DHCFP's network adequacy standards by submitting quarterly network adequacy reports to DHCFP in the required reporting format.
- The provider-to-member ratio standards were calculated by comparing each unique provider type to the number of current membership count; for example, one whole provider to one whole member calculation utilized, ensuring no duplication of members or providers. Any deficiencies in meeting this requirement were submitted to DHCFP in the state-specific 402/407 report format.
- For the GeoAccess standards, **Anthem** calculated results by using the usual route of travel (i.e., in a direct route to travel from the member's home to the provider location) distance method. Members listed as homeless or with post office (PO) Boxes on the 834 file were included in the time or distance calculations using ZIP-distributive methodology in Quest Analytics software if a valid United States Postal Service (USPS) ZIP Code was listed in the 834 file. Members who had invalid addresses and incarcerated members were excluded from these network adequacy calculations. Invalid ZIP Codes consisted of addresses with special characters (e.g., %); addresses that did not start with 0–9; addresses listed with shelter, rescue, mission, unknown, unstable, PO Box, and inmate within the address field; and the ZIP Code 89165, which was the ZIP Code used for Nevada's Department of Corrections prison inmates. **Anthem** estimated approximately 6 percent of its membership fell within these exclusion categories. DHCFP's guidance was to exclude incarcerated members, displaced members, and/or members in rehabilitation facilities.
- **Anthem** defined the "pediatric population" as ages 0 to 21 years and the "adult population" as ages 21+ years when calculating time or distance standards.
- **Anthem** conducted data reasonability checks by comparing reports with previous submissions and internal business owners reviewed to ensure reasonableness of data integrated to report network adequacy indicators.
- **Anthem** maintained network adequacy indicator reports by storing and archiving the data in its Microsoft SQL Server and labeling them with the applicable network adequacy reporting period.

- **Anthem** conducted quality checks and data validation by having quality analysts and the provider network manager review both the extracted data and the report results for any anomalies, errors, or issues. Additionally, if any time modifications were made to reporting functions, the process underwent a series of reviews and test runs prior to implementation in production environments.
- To ensure continuity of network adequacy indicator production, **Anthem** had a document on file that provided step-by-step information on the entire network adequacy reporting process, indicating what to do and how to check the data at each step. Multiple staff members from Regulatory Compliance Reporting were available as backup should the primary developer have been unavailable to perform the activities.
- HSAG assessed documented processes and programming language used to inform indicator-specific calculation of provider-to-member ratios, which demonstrated alignment with DHCFP-defined calculation and reporting requirements.
- HSAG assessed documented processes and programming language used to inform indicator-specific calculation of time or distance standards, which demonstrated that **Anthem** used a time *and* distance method when determining compliance, rather than the DHCFP-required time *or* distance to determine compliance. In addition, **Anthem** had reported specialty provider categories with the adult and pediatric populations combined, whereas DHCFP required the MCOs to report specialty provider categories for adult and pediatric populations separately for a subset of provider categories. **Anthem** requested clarification on how to identify inpatient psychiatric hospitals, for which DHCFP confirmed that **Anthem** can use Medicare CMS Certification Numbers to identify inpatient psychiatric hospitals for year one reporting.
- **Anthem** recalculated using the required accurate parameters and provided HSAG with a revised reporting template capturing results that aligned with DHCFP's required population stratification.

HSAG identified no concerns with **Anthem**'s network adequacy indicator reporting processes.

Assessment of Data Validity

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

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 8.

Table 8—Indicator-Level Validation Rating Categories

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

Below summarizes network adequacy indicators resulting in a *Low Confidence* or *No Confidence* designation.

- No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

Analysis and Conclusions

HSAG determined that the providers per 1,500 members in Clark and Washoe counties exceeded DHCFP's requirements. Results are presented by the number of providers per 1,500 members in Clark and Washoe counties by DHCFP's required provider categories in Table 9.

Table 9—Anthem Provider-to-Member Ratios by Provider Type by County

Provider Type	Indicator	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
PCP not practicing in conjunction with healthcare professional*	1:1,500	13.66	46.55
Specialists	1:1,500	137.81	296.56

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

DHCFP established a 100 percent threshold when determining compliance with time or distance standards. HSAG determined that indicators that fell below the 100 percent threshold achieved greater than or equal to 99.6 percent. Results are presented by percentage of members with access across Clark and Washoe counties by provider category in Table 10. Results that achieved the 100 percent access threshold are shaded green^.

Table 10—Anthem Percentage of Members With Access by Provider Type by County

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Primary Care, Adults	10 miles or 15 minutes	99.9%	99.7%
OB/GYN (Adult Females)	10 miles or 15 minutes	99.6%	99.7%
Pediatrician	10 miles or 15 minutes	99.9%	99.7%
Endocrinologist	40 miles or 60 minutes	99.9%	100%^
Endocrinologist, Pediatric	40 miles or 60 minutes	99.9%	100%^
Infectious Disease	40 miles or 60 minutes	99.9%	100%^
Infectious Disease, Pediatric	40 miles or 60 minutes	99.9%	100%^
Rheumatologist	40 miles or 60 minutes	99.9%	100%^
Rheumatologist, Pediatric	40 miles or 60 minutes	99.9%	100%^
Oncologist/Radiologist	40 miles or 60 minutes	100%^	100%^
Oncologist/Radiologist, Pediatric	40 miles or 60 minutes	100%^	100%^
Oncologist—Medical/Surgical	30 miles or 45 minutes	99.9%	100%^
Oncologist—Medical/Surgical, Pediatric	30 miles or 45 minutes	99.9%	100%^

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Psychologist	30 miles or 45 minutes	99.9%	100%^
Psychologist, Pediatric	30 miles or 45 minutes	99.9%	100%^
Psychiatrist	30 miles or 45 minutes	99.9%	100%^
Board Certified Child and Adolescent Psychiatrist	30 miles or 45 minutes	99.9%	100%^
Qualified Mental Health Professional (QMHP)	30 miles or 45 minutes	100%^	100%^
QMHP, Pediatric	30 miles or 45 minutes	100%^	100%^
Hospital, All	30 miles or 45 minutes	100%^	100%^
Psychiatric Inpatient Hospital	30 miles or 45 minutes	99.9%	100%^
Dialysis/End Stage Renal Disease (ESRD) Facility	30 miles or 45 minutes	99.9%	100%^
Pharmacy	10 miles or 15 minutes	99.9%	99.7%

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths

Strength #1: Anthem had strong oversight and validation processes in place to ensure completeness and accuracy in member enrollment and eligibility data processing.

Opportunities for Improvement and Recommendations

Opportunity #1: Without DHCFP guidance, HSAG observed **Anthem** excluding members who had invalid addresses or ZIP Codes from network adequacy calculation and reporting.

Recommendation: HSAG recommends **Anthem** seek additional guidance from DHCFP on any requirements related to the exclusion of members where an invalid address and/or ZIP Code is identified.

Opportunity #2: Although **Anthem** was able to apply the necessary corrections for final reporting, HSAG observed that **Anthem** was not applying the correct parameters when calculating and determining compliance with the GeoAccess standards. **Anthem** was applying "and" versus "or."

Recommendation: HSAG recommends that **Anthem** conduct a quarterly review of DHCFP reporting requirements and build in additional layers of validation to ensure logic and parameters used to inform calculations are in alignment. In addition, HSAG recommends that **Anthem** ensure internal process flows are documented to reflect changes year over year.

Opportunity #3: Although **Anthem** was able to apply the necessary corrections for final reporting, HSAG observed the DHCFP-required reporting template did not account for the MCOs' ability to report out the DHCFP-required populations, adult and pediatric, on a subset of DHCFP-defined provider categories, as well as not reporting inpatient psychiatric hospitals separately as required by DHCFP. DHCFP provided a one-time approval to allow the MCOs to modify the template to support recalculation and population stratification reporting.

Recommendation: HSAG recommends that **Anthem** work with DHCFP on future template updates to ensure all DHCFP reporting requirements are captured on the reporting template, including the necessary population stratifications.

Progress Made From Prior Year

This section is intentionally not completed since this is the first year a NAV audit, in alignment with CMS EQR Protocol 4, was conducted for **Anthem** in Nevada. During future reporting cycles, HSAG will incorporate an evaluation of each MCE's network adequacy standards progress made from the prior year.

LIBERTY Dental Plan of Nevada, Inc.

ISCA Findings and Data Validity

HSAG completed an ISCA for **LIBERTY** and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

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

- **LIBERTY** managed data internally via its core management information system (MIS), referred to as Health Solutions Plus (HSP), which maintained all required data used to inform network adequacy indicator reporting, such as member demographics and eligibility, customer service, provider information, claims processing, financial, utilization management, and other functions.

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

- **LIBERTY** had two programmers on staff who were trained and capable of modifying Quest Analytics software, SQL, and Microsoft Excel systems.
- On average, **LIBERTY**'s programmers had over 10 years of experience.

HSAG identified no concerns with **LIBERTY**'s information systems data processing procedures and personnel.

Enrollment System

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

- **LIBERTY** maintained enrollment and eligibility data for Medicaid members within HSP.
- **LIBERTY** received daily incremental and monthly full enrollment files in the 834 file format from DHCFP.
  - **LIBERTY** performed monthly reconciliation between HSP and 834 file data to ensure completeness and accuracy of enrollment data.
- **LIBERTY**'s reconciliation and oversight of enrollment data included the following:
  - **LIBERTY** retrieved 834 files through a secure file transfer protocol (SFTP) site that ran through a Health Insurance Portability and Accountability Act of 1996 (HIPAA) gateway for validation. If errors were identified in the file, the file was rejected and sent back to DHCFP to be resolved

and re-sent. Once the update was processed, the file was compared to the existing records. Any identified discrepancies were captured in a fallout report that was reviewed by **LIBERTY**'s internal staff members immediately to research, resolve, and process timely.

  - **LIBERTY** took a monthly snapshot of HSP and compared it to the monthly 834 file received from DHCFP to ensure accuracy of member data. As the 834 file is the source of truth, updates were made based on the 834 files.

- **LIBERTY** identified member demographic updates based on the 834 file received from DHCFP. HSP had an alternate field to capture any member self-reported updates to demographics information that differed from the 834 files, and **LIBERTY** advised members to notify the county to ensure changes were reflected on the 834 files.
  - HSP had the ability to store and maintain historical enrollment and eligibility information, and a history log could be generated to track changes over time.
  - **LIBERTY** conducted random spot audits monthly to validate manual edits performed by enrollment staff members.
- HSP captured and maintained both the DHCFP-issued Medicaid ID and a system generated ID. If the Medicaid ID changed for any reason, **LIBERTY** used HSP-generated ID to link enrollment history.

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

Provider Data Systems

HSAG evaluated the information systems and processes used by **LIBERTY** to capture provider data and identified the following findings:

- **LIBERTY** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data. **LIBERTY** conducted timely verification of provider information using Utilization Review Accreditation Committee (URAC) accredited sources to ensure that credentialing decisions were based on the most accurate, current, and complete information available.
- **LIBERTY** delegated the verification process to its National Committee for Quality Assurance (NCQA) and URAC Certified Verification Organization (CVO), which followed NCQA, URAC, health plan, State, and federal accrediting standards for oversight of delegated activities.
- **LIBERTY** conducted data validation activities for accuracy and completeness in the logic and methodology and consistency in calculation.
- **LIBERTY** collected data from providers in standardized formats, such as the credentialing application or Council for Affordable Quality Healthcare (CAQH) application, during initial and recredentialing processes to the extent feasible and appropriate.

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

- **LIBERTY** maintained provider credentialing and network status data in HSP.
- **LIBERTY** captured DHCFP-required provider categories and specialties in HSP. **LIBERTY**'s PDM department captured the provider type based on the specialty for which the provider was credentialed. This was then verified by **LIBERTY**'s System Configuration department.
- **LIBERTY**'s procedures for updating and maintaining provider data included:
  - **LIBERTY**'s PDM team entered provider data in HSP once credentialing was approved. **LIBERTY**'s HSP system maintained history to track providers over time, across multiple office locations, and through changes in participation in **LIBERTY**'s network.
  - The PDM team also entered manually any updates received from providers or received through other ongoing provider data monitoring processes.
  - **LIBERTY** had internal monthly audits in place to ensure the accuracy of any manual edits performed by the PDM team.
  - **LIBERTY** relied on the credentialing and screening process and results conducted by its delegated CVO to identify providers or organizations excluded from the Medicaid program each month (e.g., List of Excluded Individuals/Entities, etc.).
- **LIBERTY** required its provider network to update provider data quarterly via self-reported updates through a provider portal. Providers were made aware of this expectation through provider-facing newsletters, provider alerts on the provider portal, service calls, and **LIBERTY** provider representative site visits.

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

Delegated Entity Data and Oversight

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

- **LIBERTY** did not subcontract any network adequacy-related services to delegated entities.

Network Adequacy Indicator Reporting

HSAG's assessment of **LIBERTY**'s network adequacy indicator reporting processes included the following findings:

- **LIBERTY** used Quest Analytics software to calculate and report network adequacy indicators.
- **LIBERTY** integrated three data sources for network adequacy indicator reporting. The three data sources integrated were:
  - Member data extracted from HSP, including the unique plan member ID numbers and address information to ensure only unique members were counted.
  - Provider data extracted from HSP, including provider ID, specialty, location, and contract status.

  - Geographic data including information such as ZIP Code boundaries, driving distances, and travel times.
  - **LIBERTY** utilized Quest Analytics software's built-in geographic data along with external data sources to inform calculation and reporting activities.
- **LIBERTY** used appropriate methodologies to assess adherence to DHCFP's network adequacy standards:
  - For time or distance, member and provider data were extracted from **LIBERTY**'s MIS reporting environment and staged within a Microsoft SQL Server. Quest Analytics software—a DHCFP-approved, industry standard third-party software—was used to calculate time or distance, referencing the staged data, and to produce time or distance reporting. Quest Analytics' proprietary algorithm used the estimated driving distance method for calculating time or distance. Data from Quest Analytics software was then populated onto DHCFP reporting templates and submitted to DHCFP quarterly. **LIBERTY** defined the "pediatric population" as ages 0 to 20 years and the "adult population" as ages 21 years and older when calculating and determining compliance with time or distance standards.
- For provider-to-member ratios, member and provider data were extracted from **LIBERTY**'s MIS and used to compare FTE providers at each office to the number of assigned members to generate the provider-to-member ratios. The ratios were populated onto DHCFP reporting templates and submitted to DHCFP quarterly. **LIBERTY** conducted data reasonability checks by employing quality checks at each step in its process, and ongoing management and leadership staff review. **LIBERTY** maintained network adequacy indicator reports by ensuring reported results were archived and labeled, as well as saved and maintained over time, to ensure version control.
- **LIBERTY** conducted peer review of programming code in GeoAccess software. It compared reports from prior years to conduct trend analyses quarter over quarter, which were sent to management staff for review. To ensure continuity of network adequacy indicator production, **LIBERTY** had policies and procedures in place to follow if needed and had internal backups to produce network adequacy indicator reports.
- HSAG assessed documented processes and programming language used to inform indicator-specific calculation of provider-to-member ratios and time or distance, which demonstrated alignment with DHCFP-defined calculation and reporting requirements.

HSAG identified no concerns with **LIBERTY**'s network adequacy indicator reporting processes.

Assessment of Data Validity

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

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 11.

Table 11—Indicator-Level Validation Rating Categories

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

Below summarizes network adequacy indicators resulting in a *Low Confidence* or *No Confidence* designation.

- No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

Analysis and Conclusions

HSAG determined that the providers per 1,500 members in Clark and Washoe counties exceeded DHCFP's requirements. Results are presented by the number of providers per 1,500 members in Clark and Washoe counties by DHCFP's required provider categories in Table 12.

Table 12—LIBERTY Provider-to-Member Ratios by Provider Type by County

Provider Type	Indicator	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
Dental PCP	1:1,500	1.16	1.43

DHCFP established a 100 percent threshold when determining compliance with time or distance standards. HSAG determined that indicators that fell below the 100 percent threshold achieved greater than or equal to 99.9 percent, except for both Periodontist and Prosthodontist in Washoe County, which resulted in 0 percent access. Results are presented by percentage of members with access across Clark and Washoe counties by provider type in Table 13. Results that achieved the 100 percent access threshold are shaded green^.

Table 13—LIBERTY Percentage of Members With Access by Provider Type by County

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
General Dentist	20 miles or 30 minutes	99.9%	99.9%
Dentist, Pediatric	20 miles or 30 minutes	99.9%	99.9%
Endodontist	40 miles or 60 minutes	99.9%	100%^
Periodontist	40 miles or 60 minutes	99.9%	0%
Prosthodontist	40 miles or 60 minutes	99.9%	0%
Oral Surgeon	40 miles or 60 minutes	99.9%	99.9%
Dental Hygienist	40 miles or 60 minutes	99.9%	99.9%
Dental Therapist*	40 miles or 60 minutes	NA	NA

*NA: DHCFP granted an exception for reporting the Dental Therapist provider type due to no known dental therapists servicing the area.

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths

Strength #1: LIBERTY has established robust processes to keep provider data up to date and accurate through its quarterly provider directory validation, credentialing process, and monthly monitoring of the multiple sanction/exclusion lists.

Strength #2: LIBERTY maintained a well-documented deliverable validation process, which included ongoing maintenance of member and provider data to ensure the accuracy of the quarterly network adequacy calculation and report submissions.

Opportunities for Improvement and Recommendations

Opportunity #1: Although **LIBERTY** was able to apply the necessary corrections for final reporting, HSAG observed **LIBERTY** was not reporting Dental Hygienist providers on the 407 GeoAccess reports, as required by DHCFP.

Recommendation: HSAG recommends that **LIBERTY** perform a quarterly review of DHCFP reporting requirements and build in additional layers of validation to ensure logic and parameters used to inform calculations are in alignment. In addition, HSAG recommends that **LIBERTY** ensure internal process flows are documented to reflect changes year over year.

Progress Made From Prior Year

This section is intentionally not completed since this is the first year a NAV audit, in alignment with CMS EQR Protocol 4, was conducted for **LIBERTY**, in Nevada. During future reporting cycles, HSAG will incorporate an evaluation of each MCE's network adequacy standards progress made from the prior year.

Molina Healthcare of Nevada, Inc.

ISCA Findings and Data Validity

HSAG completed an ISCA for **Molina** and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

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

- **Molina** used QNXT as its eligibility and enrollment, and its provider network management database system.
- **Molina** used Microsoft SQL Server 2019 to extract all relevant source data using structured SQL programming for network adequacy indicator calculation and reporting.
- **Molina** used Quest Analytics software to calculate the required GeoAccess standards used to determine compliance with time or distance standards.

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

- **Molina** had over 25 programmers who were trained and capable of modifying the data-extracting programs.
- **Molina**'s IT personnel had a minimum of over 10 years' experience to support the IT processes used to inform network adequacy reporting activities.

HSAG identified no concerns with **Molina**'s information systems data processing procedures and personnel.

Enrollment System

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

- **Molina** maintained enrollment and eligibility data for Medicaid members within QNXT.
- **Molina** received daily and monthly enrollment files in the 834 file format from DHCFP and processed them within 24 hours.
- **Molina** performed monthly reconciliation between QNXT and the 834 data file to ensure the completeness and accuracy of enrollment data.
- **Molina**'s reconciliation and oversight of enrollment data included the following:

  - **Molina** had an automated process in place to load the 834 data file with build system edits to flag any potential data discrepancies. If discrepancies were identified, the member records would reject and flow to **Molina**'s Member Workflow process and assigned to a **Molina** enrollment representative for manual research and resolution. This process was monitored daily.
  - **Molina** enrollment representatives were audited monthly by the enrollment audit team to validate the accuracy of any manual edits performed by the enrollment representatives.
- The **Molina** system captured and maintained both the DHCFP-issued Medicaid ID and a QNXT-generated ID. If the Medicaid ID changed for any reason, **Molina** used the QNXT-generated ID to link enrollment history. For network adequacy reporting, the DHCFP-issued Medicaid ID was used as the source of truth.
- **Molina** identified member demographic updates based on the daily and monthly 834 enrollment files. HSAG identified no concerns with **Molina**'s enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by **Molina** to capture provider data and identified the following findings:

- **Molina** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- **Molina** screened the data for completeness, logic, and consistency.
- **Molina** collected data from providers in standardized formats (e.g., credentialing applications), to the extent feasible and appropriate.

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

- **Molina** maintained provider credentialing data in CACTUS. Once provider credentialing was approved, the information was added to QNXT.
- **Molina** maintained provider network status data in QNXT.
- **Molina** captured DHCFP-required provider categories and specialties in QNXT. **Molina** maintained an internal crosswalk of specialty and taxonomy codes by specialty type. The crosswalk was used to identify specific provider types required for reporting each of the indicators in scope of review. All providers were matched in NPPES with their taxonomy code and National Provider Identifier (NPI) for validation before being entered into QNXT. During the credentialing process, the providers were verified with the State of Nevada licensing board then reaffirmed every three years.
- **Molina**'s procedures for updating and maintaining provider data included:
  - **Molina** medical groups submitted provider roster updates quarterly, which were reconciled within QNXT.
  - **Molina** collected updated provider information upon the recredentialing process, which occurred every three years.

  - **Molina** collected updated demographic information through quarterly secret shopper surveys, which verified demographics, office hours, and whether the provider was accepting new patients.
  - **Molina**'s quality assurance program audited provider data entry on a sample basis daily.
  - **Molina** reviewed NPPES reports for inactive NPIs and removed providers without an active NPI.
- **Molina** used QNXT to track providers over time, across multiple office locations, and through changes in participation in **Molina**'s network.
- **Molina** relied on the Active Provider Report, which was received by DHCFP to identify providers or organizations excluded from the Medicaid program each month.
- **Molina** required its provider network to update provider data through the quarterly provider roster update submissions and any time provider demographics were changed, as needed. Providers were made aware of this expectation through provider contract language.

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

Delegated Entity Data and Oversight

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

- **Molina** subcontracted credentialing services to two network provider groups, Renown Health Care and University of Nevada, Las Vegas School of Medicine. Provider rosters and credentialing information were used from these two provider groups for network adequacy calculations and reporting.
- **Molina** maintained oversight of its delegated entities by as following:
  - **Molina**'s delegation oversight team conducted quarterly audits of each delegated entity's provider credentialing information.
  - **Molina** collected monthly delegated activity reports and quarterly provider rosters to maintain accurate provider network information.
  - Delegation agreements included language designed to ensure delegated entities met data accuracy, completeness, and timeliness standards, and defined requirements for reporting of provider data.
  - **Molina** met with each delegated entity monthly to review the results of quarterly audits and discuss any improvement plans in place.
- **Molina** did not identify any delegated entity network adequacy data-related items requiring corrective action for the time frame in scope of the NAV audit.

Network Adequacy Indicator Reporting

HSAG's assessment of **Molina**'s network adequacy indicator reporting processes included the following findings:

- **Molina** used Quest Analytics software to calculate and report the time or distance network adequacy indicators.
- **Molina** integrated two data sources for network adequacy indicator reporting: Medicaid member and provider network data extracted from QNXT.
- **Molina** maintained data control procedures to ensure the accuracy and completeness of data merges used in the time or distance calculations from QNXT by extracting the member and provider data from QNXT using SQL code and staging them in tables in Databricks software. These Databricks tables were then integrated into Quest Analytics software for the time or distance standards to be calculated.
  - Quest Analytics software generated output error reports, which flagged any data elements that were invalid.
- **Molina** used appropriate methodologies to assess adherence to DHCFP's network adequacy standards by submitting quarterly network adequacy reports to DHCFP in the required reporting format.
- The provider-to-member ratio standards were calculated by comparing each unique provider type to the number of current membership count; for example, one whole provider to one whole member calculation utilized, ensuring no duplication of members or providers. The results were reviewed monthly to ensure **Molina** had the appropriate number of provider categories per member. Any deficiencies in meeting this requirement were submitted to DHCFP in the DHCFP-specific 402/407 report format.
- For the time or distance standards, **Molina** calculated GeoAccess standards using usual travel (i.e., in a direct route to travel from the members' home to the provider location). All members listed with a valid USPS ZIP Code were included in the time or distance calculations. **Molina** estimated less than 1 percent of its membership fell into this exclusion category. The Databricks tables generated from data extraction from QNXT using SQL programming code were then integrated into Quest Analytics software to calculate. Quest Analytics software generated output error reports, which flagged any data elements missing or invalid.
- **Molina** defined the "pediatric population" as all members ages 0 to 216 months and the "adult population" as members ages >216 months.
- **Molina** conducted data reasonability checks by comparing previous network adequacy results with the current results and reviewing for any variances in data and data trends.
- **Molina** maintained network adequacy indicator reports by archiving them on **Molina**'s Microsoft SharePoint site. Additionally, **Molina** Enterprise Information Management (EIM) used Microsoft Azure DevOps/Git for version tracking and source control of source code. Programming logic and data files used for each reporting period were saved in separate folders.
- **Molina** conducted quality checks to review the accuracy of its network adequacy indicator reporting programs by having the results validated by the business team, which reviewed the overall report for logical coherence and sampled a set of individual member detail lines to validate manually and ensuring the network adequacy data were accurate and compliant with the report rules and requirements set by DHCFP.

- To ensure continuity of network adequacy indicator production, **Molina** cross-trained EIM staff members to certify all staff members had the skill set to perform the duties required to produce the network adequacy reports. Additionally, a standard operating procedure was in place to safeguard continuity to produce the required reports.
- HSAG assessed manual documented processes and programming language used to inform indicator-specific calculation of provider-to-member ratios, which demonstrated alignment with DHCFP-defined calculation and reporting requirements.
- HSAG assessed documented processes and programming language used to inform indicator-specific calculation of time or distance standards, which demonstrated that **Molina** used a time *and* distance method when determining compliance, rather than the DHCFP-required time *or* distance to determine compliance. In addition, **Molina** had reported specialty provider categories with the adult and pediatric populations combined, whereas DHCFP required the MCOs to report specialty provider categories for adult and pediatric populations separately for a subset of provider categories. Molina recalculated using the required accurate parameters and provided HSAG with a revised reporting template capturing results that aligned with DHCFP's required population stratification.

HSAG identified no concerns with **Molina**'s network adequacy indicator reporting processes.

Assessment of Data Validity

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

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 14.

Table 14—Indicator-Level Validation Rating Categories

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

Below summarizes network adequacy indicators resulting in a *Low Confidence* or *No Confidence* designation.

- No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

Analysis and Conclusions

HSAG determined that the providers per 1,500 members in Clark and Washoe counties exceeded DHCFP's requirements. Results are presented by the number of providers per 1,500 members in Clark and Washoe counties by DHCFP's required provider categories in Table 15.

Table 15—Molina Provider-to-Member Ratios by Provider Type by County

Provider Type	Indicator	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
PCP not practicing in conjunction with healthcare professional*	1:1,500	7.73	13.37
Specialists	1:1,500	39.47	81.55

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

DHCFP established a 100 percent threshold when determining compliance with time or distance standards. HSAG determined that indicators that fell below the 100 percent threshold achieved greater than or equal to 96.2 percent. Results are presented by percentage of members with access across Clark

and Washoe counties by provider type in Table 16. Results that achieved the 100 percent access threshold are shaded green^.

Table 16—Molina Percentage of Members With Access by Provider Type by County

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Primary Care, Adults	10 miles or 15 minutes	99.9%	99.6%
OB/GYN (Adult Females)	10 miles or 15 minutes	99.6%	96.2%
Pediatrician	10 miles or 15 minutes	99.9%	99.7%
Endocrinologist	40 miles or 60 minutes	99.9%	100%^
Endocrinologist, Pediatric	40 miles or 60 minutes	100%^	100%^
Infectious Disease	40 miles or 60 minutes	99.9%	100%^
Infectious Disease, Pediatric	40 miles or 60 minutes	100%^	100%^
Rheumatologist	40 miles or 60 minutes	99.9%	100%^
Rheumatologist, Pediatric	40 miles or 60 minutes	100%^	100%^
Oncologist/Radiologist	40 miles or 60 minutes	99.9%	100%^
Oncologist/Radiologist, Pediatric	30 miles or 45 minutes	100%^	100%^
Oncologist—Medical/Surgical	30 miles or 45 minutes	99.9%	99.9%
Oncologist—Medical/Surgical, Pediatric	30 miles or 45 minutes	100%^	99.9%
Psychologist	30 miles or 45 minutes	100%^	99.9%
Psychologist, Pediatric	30 miles or 45 minutes	100%^	99.9%
Psychiatrist	30 miles or 45 minutes	99.9%	99.9%
Board Certified Child and Adolescent Psychiatrist	30 miles or 45 minutes	100%^	99.9%
Qualified Mental Health Professional (QMHP)	30 miles or 45 minutes	99.9%	100%^

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
QMHP, Pediatric	30 miles or 45 minutes	100%^	100%^
Hospital, All	30 miles or 45 minutes	99.9%	100%^
Psychiatric Inpatient Hospital	30 miles or 45 minutes	99.9%	99.9%
Dialysis/End Stage Renal Disease (ESRD) Facility	30 miles or 45 minutes	99.9%	99.9%
Pharmacy	10 miles or 15 minutes	99.9%	99.7%

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths

Strength #1: Molina established robust processes to mitigate missing or incomplete data from the 834 eligibility and enrollment files by generating fallout or exceptions reports, which were manually reviewed and resolved within two business days following receipt. Manually edited member enrollment records were audited through random sampling logic to ensure ongoing accuracy and completeness of data.

Opportunities for Improvement and Recommendations

Opportunity #1: Although **Molina** was able to apply the necessary corrections for final reporting, HSAG observed that **Molina** was not applying the correct parameters when calculating and determining compliance with the GeoAccess standards. **Molina** was applying "and" versus "or."

Recommendation: HSAG recommends that **Molina** conduct a quarterly review of DHCFP reporting requirements and build in additional layers of validation to ensure logic and parameters used to inform calculations are in alignment. In addition, HSAG recommends that **Molina** ensure internal process flows are documented to reflect changes year over year.

Opportunity #2: Although **Molina** was able to apply the necessary corrections for final reporting, HSAG observed the DHCFP-required reporting template did not account for the MCOs' ability to report out the DHCFP-required populations, adult and pediatric, on a subset of DHCFP-defined provider categories as well as not reporting inpatient psychiatric hospitals separately as required by

DHCFP. DHCFP provided a one-time approval to allow the MCOs to modify the template to support recalculation and population stratification reporting.

Recommendation: HSAG recommends that **Molina** work with DHCFP on future template updates to ensure all DHCFP reporting requirements are captured on the reporting template, including the necessary population stratifications.

Progress Made From Prior Year

This section is intentionally not completed since this is the first year a NAV audit, in alignment with CMS EQR Protocol 4, was conducted for **Molina** in Nevada. During future reporting cycles, HSAG will incorporate an evaluation of each MCE's network adequacy standards progress made from the prior year.

SilverSummit Healthplan, Inc.

ISCA Findings and Data Validity

HSAG completed an ISCA for **SilverSummit** and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

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

- **SilverSummit** used Unified Member View (UMV) as its eligibility and enrollment database system.
- **SilverSummit** used Portico as its provider network management database system.
- A SQL database and programming language were used to extract network adequacy indicator data from data source systems.
- **SilverSummit** used Quest Analytics software to calculate the required GeoAccess standards used to determine compliance with time or distance standards. HSAG evaluated the personnel that **SilverSummit** had in place to support network adequacy indicator reporting, which included the following findings:
- **SilverSummit** had two programmers, with a combined average of nine years' experience, who were trained and capable of network adequacy analytic reporting.

HSAG identified no concerns with **SilverSummit**'s information systems data processing procedures and personnel.

Enrollment System

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

- **SilverSummit** maintained enrollment and eligibility data for Medicaid members within UMV.
- **SilverSummit** received daily and monthly enrollment files in the 834 file format from DHCFP that were processed within 24 hours of receipt.
- **SilverSummit** performed monthly reconciliation between UMV and the 834 data file to ensure the completeness and accuracy of enrollment data.
- **SilverSummit**'s reconciliation and oversight of enrollment data included the following:
  - **SilverSummit** validated the file record count to ensure 100 percent of DHCFP's file records were processed into UMV.

  - Automated error reports were generated daily, and any errors detected were worked and resolved prior to loading member records into the main Amisys system for disbursement to downstream source data systems.
  - The DHCFP portal was utilized by **SilverSummit**'s eligibility representatives to investigate and resolve member enrollment discrepancies.
  - If needed, **SilverSummit**'s enrollment and eligibility team would reach out to Centene's Government Contracts and Compliance departments to communicate any outstanding issues with DHCFP directly and support timely resolution.
- UMV captured and maintained both the DHCFP-issued Medicaid ID and a unique UMV-generated ID. If the Medicaid ID changed for any reason, **SilverSummit** used the unique UMV-generated ID to link enrollment history. For network adequacy reporting, the DHCFP-issued Medicaid ID was used as the primary identifier and source of truth.

SilverSummit identified member demographic updates based on the daily and monthly 834 enrollment files. HSAG identified no concerns with **SilverSummit**'s enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by **SilverSummit** to capture provider data and identified the following findings:

- **SilverSummit** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- **SilverSummit** screened the data for completeness, logic, and consistency.
- **SilverSummit** collected data from providers in standardized formats (e.g., credentialing applications), to the extent feasible and appropriate.

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

- **SilverSummit** maintained provider credentialing data in CenProv, a corporate provider database system, contained provider demographic information and supporting documentation obtained during the credentialing process. Once provider credentialing was approved, the information was added to Portico.
- **SilverSummit** maintained provider network status data in Portico.
- **SilverSummit** used an internal crosswalk to map the specialty types to taxonomies and to the specialties in Portico. Its Provider Data Quality team performed routine audits and quality assurance to ensure accuracy.
- **SilverSummit**'s procedures for updating and maintaining provider data included:
  - **SilverSummit** conducted quarterly provider outreach audits to verify provider demographic data and conducted telephonic outreached to highly utilized specialty providers to verify demographic data.

  - **SilverSummit**'s PDM team verified self-reported provider Medicaid IDs monthly.
- All active Medicaid providers listed in CenProv and Portico were reconciled against DHCFP's Active Provider Report to ensure **SilverSummit** had accurate NPI numbers. Additionally, **SilverSummit** met monthly with DHCFP to review and reconcile active and inactive NPIs.
- **SilverSummit** used Portico to track providers over time, across multiple office locations, and through changes in participation in **SilverSummit**'s network.
- **SilverSummit** relied on the Active Provider Report, which was sent by DHCFP monthly, to identify providers or organizations excluded from the Medicaid program each month.
- **SilverSummit** required its provider network to update provider data every three years during the recredentialing process or any time provider demographics were changed, as needed. Providers were made aware of this expectation through provider contract language.

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

Delegated Entity Data and Oversight

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

- **SilverSummit** did not subcontract any network adequacy-related services to delegated entities.

Network Adequacy Indicator Reporting

HSAG's assessment of **SilverSummit**'s network adequacy indicator reporting processes included the following findings:

- **SilverSummit** used Quest Analytics software to calculate and report network adequacy indicators related to time or distance.
- **SilverSummit** integrated two data sources for network adequacy indicator reporting: Medicaid member data from UMV and provider data from Portico.
- **SilverSummit** maintained data control procedures to ensure accuracy and completeness of data merges from UMV and Portico by extracting the raw data using SQL code and staging them in Microsoft SQL Server tables. These tables were then integrated into Quest Analytics software to conduct GeoAccess analysis.
- **SilverSummit** used tools such as Portico, an internal provider crosswalk, and data cleansing procedures to ensure the integrity and accuracy of the data.
- The internal provider crosswalk helped **SilverSummit** integrate the required reporting specialty naming conventions outlined in the Medicaid contract.
  - **SilverSummit** implemented validation rules to identify and remove erroneous data entries, duplicate addresses, mismatched files, and incomplete records.

  - Advanced deduplication algorithms were applied to eliminate duplicate entries, ensuring that each provider was represented uniquely in its dataset.
  - Addresses and other key fields were standardized to a common format to facilitate accurate analysis and reporting.
- **SilverSummit** used appropriate methodologies to assess adherence to DHCFP's network adequacy standards by submitting quarterly network adequacy reports to DHCFP in the required reporting format.
- The provider-to-member ratio standards were calculated by comparing each unique provider type to the number of current membership count; for example, one whole provider to one whole member calculation utilized, ensuring no duplication of members or providers. Any deficiencies in meeting this requirement were submitted to DHCFP in the DHCFP-specific 402/407 report format.
- For the GeoAccess standards, **SilverSummit** calculated results by using the usual travel (i.e., in a direct route to travel from the member's home to the provider location) distance method. Members listed as homeless or with an invalid or missing ZIP Code were excluded from the time or distance calculations. Members with a valid USPS ZIP Code but invalid address were included using ZIP-Distributive methodology. **SilverSummit** estimated approximately 7 percent of its membership fell within this exclusion category. DHCFP's guidance was to exclude displaced members.
- **SilverSummit** defined the "pediatric population" as ages 0 to 17 years and the "adult population" as ages 18+ years when calculating time or distance standards.
- **SilverSummit** conducted data reasonability checks by comparing each network adequacy report to the previous month to ensure that any changes were reasonable and expected based on its provider network.
- **SilverSummit** maintained network adequacy indicator reports by archiving the data files in its SQL database and labeling them with the applicable network adequacy reporting period.
- **SilverSummit** conducted quality checks and data validation using the SQL-connected file in the template provided by DHCFP. All network adequacy reporting programs were reviewed annually by Business and Technical leadership to ensure requirements were documented and consistent with current business processes.
- To ensure continuity of network adequacy indicator production, **SilverSummit** had programmers and developers skilled in SQL programming language and had a redundancy protocol to support programmers on leave or paid time off, as well as backup in case of emergency. Requirements of the network adequacy reporting activities were recorded in the Jira ticketing software, as well as in business requirement documents in Microsoft Word in shared folder environments.
- HSAG assessed documented processes and programming language used to inform indicator-specific calculation of provider-to-member ratios, which demonstrated alignment with DHCFP-defined calculation and reporting requirements.
- HSAG assessed documented processes and programming language used to inform indicator-specific calculation of time or distance standards, which demonstrated that **SilverSummit** used a time *and* distance method when determining compliance, rather than the DHCFP-required time *or* distance to determine compliance. In addition, **SilverSummit** had reported specialty provider categories with the adult and pediatric populations combined, whereas DHCFP required the MCOs to report

specialty provider categories for adult and pediatric populations separately for a subset of provider categories. **SilverSummit** recalculated using the required accurate parameters and provided HSAG with a revised reporting template capturing results that aligned with DHCFP's required population stratification.

HSAG identified no concerns with **SilverSummit**'s network adequacy indicator reporting processes.

Assessment of Data Validity

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

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 17.

Table 17—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*

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

Below summarizes network adequacy indicators resulting in a *Low Confidence* or *No Confidence* designation.

- No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

Analysis and Conclusions

HSAG determined that the providers per 1,500 members in Clark and Washoe counties exceeded DHCFP's requirements. Results are presented by the number of providers per 1,500 members in Clark and Washoe counties by DHCFP's required provider categories in Table 18.

Table 18—SilverSummit Provider-to-Member Ratios by Provider Type by County

Provider Type	Indicator	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
PCP not practicing in conjunction with healthcare professional*	1:1,500	17.65	33.40
Specialists	1:1,500	97.89	263.03

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

DHCFP established a 100 percent threshold when determining compliance with time or distance standards. HSAG determined that indicators that fell below the 100 percent threshold achieved greater than or equal to 99.5 percent. Results are presented by percentage of members with access across Clark and Washoe counties by provider type in Table 19. Results that achieved the 100 percent access threshold are shaded green^.

Table 19—SilverSummit Percentage of Members With Access by Provider Type by County

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Primary Care, Adults	10 miles or 15 minutes	99.9%	99.6%

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
OB/GYN (Adult Females)	10 miles or 15 minutes	99.9%	99.5%
Pediatrician	10 miles or 15 minutes	99.9%	99.7%
Endocrinologist	40 miles or 60 minutes	99.9%	100%^
Endocrinologist, Pediatric	40 miles or 60 minutes	99.9%	100%^
Infectious Disease	40 miles or 60 minutes	99.9%	100%^
Infectious Disease, Pediatric	40 miles or 60 minutes	100%^	100%^
Rheumatologist	40 miles or 60 minutes	99.9%	100%^
Rheumatologist, Pediatric	40 miles or 60 minutes	99.9%	100%^
Oncologist/Radiologist	40 miles or 60 minutes	100%^	100%^
Oncologist/Radiologist, Pediatric	40 miles or 60 minutes	100%^	100%^
Oncologist—Medical/Surgical	30 miles or 45 minutes	100%^	99.9%
Oncologist—Medical/Surgical, Pediatric	30 miles or 45 minutes	99.9%	100%^
Psychologist	30 miles or 45 minutes	99.9%	100%^
Psychologist, Pediatric	30 miles or 45 minutes	99.9%	100%^
Psychiatrist	30 miles or 45 minutes	100%^	99.9%
Board Certified Child and Adolescent Psychiatrist	45 minutes or 30 miles	99.9%	100%^
Qualified Mental Health Professional (QMHP)	30 miles or 45 minutes	100%^	100%^
QMHP, Pediatric	30 miles or 45 minutes	100%^	100%^

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Hospital, All	30 miles or 45 minutes	100%^	100%^
Psychiatric Inpatient Hospital	30 miles or 45 minutes	99.9%	99.9%
Dialysis/End Stage Renal Disease (ESRD) Facility	30 miles or 45 minutes	100%^	100%^
Pharmacy	10 miles or 15 minutes	99.9%	99.7%

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths

Strength #1: SilverSummit established robust processes to mitigate missing or incomplete data from the 834 eligibility and enrollment files by running two types of error reports prior to the member data being incorporated into its MIS. **SilverSummit** manually reviewed and corrected 100 percent of errors.

Strength #2: SilverSummit's PDM team audited 100 percent of provider data entries that were uploaded from the provider database system, Portico, to its claims system, Amisys.

Opportunities for Improvement and Recommendations

Opportunity #1: SilverSummit excluded members who had invalid addresses from network adequacy calculations and reporting.

Recommendation: HSAG recommends **SilverSummit** seek additional DHCFP guidance on ways to improve capturing valid addresses on the 834 file, as this resulted in approximately 7 percent of the Medicaid population being excluded from these calculations and reporting.

Opportunity #2: Although **SilverSummit** was able to apply the necessary corrections for final reporting, HSAG observed that **SilverSummit** was not applying the correct parameters when calculating and determining compliance with the GeoAccess standards. **SilverSummit** was applying "and" versus "or."

Recommendation: HSAG recommends that **SilverSummit** conduct a quarterly review of DHCFP reporting requirements and build in additional layers of validation to ensure logic and parameters

used to inform calculations are in alignment. In addition, HSAG recommends that **SilverSummit** ensure internal process flows are documented to reflect changes year over year.

Opportunity #3: Although **SilverSummit** was able to apply the necessary corrections for final reporting, HSAG observed the DHCFP-required reporting template did not account for the MCOs' ability to report out the DHCFP-required populations, adult and pediatric, on a subset of DHCFP-defined provider categories as well as not reporting inpatient psychiatric hospitals separately as required by DHCFP. DHCFP provided a one-time approval to allow the MCOs to modify the template to support recalculation and population stratification reporting.

Recommendation: HSAG recommends that **SilverSummit** work with DHCFP on future template updates to ensure all DHCFP reporting requirements are captured on the reporting template, including the necessary population stratifications.

Progress Made From Prior Year

This section is intentionally not completed since this is the first year a NAV audit, in alignment with CMS EQR Protocol 4, was conducted for **SilverSummit** in Nevada. During future reporting cycles, HSAG will incorporate an evaluation of each MCE's network adequacy standards progress made from the prior year.

UnitedHealthcare Health Plan of Nevada Medicaid

ISCA Findings and Data Validity

HSAG completed an ISCA for **UHC HPN** and presents the ISCA findings and assessment of any concerns related to data sources used in the NAV.

Information Systems Data Processing Procedures and Personnel

HSAG evaluated the information systems data processing procedures that **UHC HPN** had in place to support network adequacy indicator reporting, which included the following findings:

- **UHC HPN** used Facets as its eligibility and enrollment database system.
- **UHC HPN** used eVIPS as its provider network management database system.
- A Microsoft Access database called Smartchoice and queries were used to extract network adequacy indicator data from data source systems.
- **UHC HPN** used Quest Analytics software to calculate the required GeoAccess standards used to determine compliance with time or distance standards. HSAG evaluated the personnel that **UHC HPN** had in place to support network adequacy indicator reporting, which included the following findings:
- **UHC HPN** had one primary programmer and two backup staff members, with an average of 22 years' experience, who were trained and capable of supporting network adequacy analytic reporting activities.

HSAG identified no concerns with **UHC HPN**'s information systems data processing procedures and personnel.

Enrollment System

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

- **UHC HPN** maintained enrollment and eligibility data for Medicaid members within the Facets system.
- **UHC HPN** received daily and monthly enrollment files in the 834 file format from DHCFP, which were processed within 24 hours of receipt.
- **UHC HPN** performed monthly reconciliation between its Facets system and the 834 data file to ensure the completeness and accuracy of enrollment data.
- **UHC HPN**'s reconciliation and oversight of enrollment data included the following:

  - **UHC HPN**'s automated processing of 834 files into Facets only allowed for fully compliant files to be loaded. Any noncompliant files would trigger an alert notifying the IT department, who then sent notification of noncompliant files to the Medicaid Enrollment and Compliance teams to outreach to DHCFP's vendor, Gainwell Technology, for verification or resolution.
- **UHC HPN**'s system captured and maintained both the DHCFP-issued Medicaid ID and a Facets-generated ID. If the Medicaid ID changed for any reason, **UHC HPN** used the Facets-generated ID to link enrollment history. For network adequacy reporting, the Facets-generated ID was used as the source of truth.

UHC HPN identified member demographic updates based on the daily and monthly 834 enrollment files. HSAG identified no concerns with **UHC HPN**'s enrollment data capture, data processing, data integration, data storage, or data reporting.

Provider Data Systems

HSAG evaluated the information systems and processes used by **UHC HPN** to capture provider data and identified the following findings:

- **UHC HPN** ensured that data received from providers were accurate and complete by verifying the accuracy and timeliness of reported data.
- **UHC HPN** screened the data for completeness, logic, and consistency.
- **UHC HPN** collected data from providers in standardized formats (e.g., credentialing applications), to the extent feasible and appropriate.

HSAG's evaluation of **UHC HPN**'s provider data system(s) included the following findings:

- **UHC HPN** maintained provider credentialing data in eVIPS.
- **UHC HPN** maintained provider network status data in eVIPS and uploaded the data into **UHC HPN**'s claims system, Facets.
- **UHC HPN** captured DHCFP-required provider categories and specialties in eVIPS. **UHC HPN** used a Network Adequacy MCO Crosswalk from prior years. **UHC HPN** conducted a cross-reference of provider specialty and taxonomy codes against the Network Adequacy MCO Crosswalk to ensure data alignment and performed regular audits on provider classifications to verify the accuracy of crosswalk implementation.
- **UHC HPN**'s procedures for updating and maintaining provider data included:
  - Providers were required to provide a source of truth for all self-reported demographics at the time of contracting and credentialing.
  - Once contracted, providers were required to attest to their demographic information every 90 days through the Online Provider Portal (OPC).
  - **UHC HPN**'s Contracting team received demographic updates daily from providers through email or letters, which were updated in eVIPS immediately.

  - **UHC HPN** required its provider network to update provider data during the recredentialing process, which is conducted every three years.
  - **UHC HPN**'s Provider Advocacy team conducted monthly secret shopper outreach calls to providers to check for any unreported demographic updates. Additionally, demographic information was confirmed during site visits to ensure provider locations were meeting the Americans with Disabilities Act (ADA) compliance requirements.
- **UHC HPN** used eVIPS to track providers over time, across multiple office locations, and through changes in participation in **UHC HPN**'s network.
- **UHC HPN** relied on the Active Provider Report, which was received from DHCFP to identify providers or organizations excluded from the Medicaid program each month.
- **UHC HPN** required its provider network to update provider data every three years during the recredentialing process, every 90 days on the OPC, or any time provider demographics were changed, as needed. Providers were made aware of this expectation through provider contract language.

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

Delegated Entity Data and Oversight

HSAG's assessment of **UHC HPN**'s delegated entity data and oversight included the following findings:

- **UHC HPN** did not subcontract any network adequacy-related services to delegated entities.

Network Adequacy Indicator Reporting

HSAG's assessment of **UHC HPN**'s network adequacy indicator reporting processes included the following findings:

- **UHC HPN** used Quest Analytics software to calculate and report network adequacy indicators related to time or distance.
- **UHC HPN** integrated two data sources for network adequacy indicator reporting: Medicaid member data from the Facets system and provider data from eVIPS.
- **UHC HPN** maintained data control procedures to ensure accuracy and completeness of data merges from Facets and eVIPS by extracting the raw data using queries that were imported into a relational database, Microsoft Access Smartchoice, through generated query tables. These tables were then integrated into Quest Analytics software for the time or distance standards to be calculated.
- **UHC HPN** used appropriate methodologies to assess adherence to DHCFP's network adequacy standards by submitting the quarterly network adequacy reports to DHCFP in the required reporting format.

  - For the provider-to-member ratio standards, **UHC HPN**'s methodology captured the logic used to determine FTE providers. **UHC HPN** advised that it interpreted DHCFP's contract language to mean that **UHC HPN** should adjust the FTE calculations to take into consideration the provider's availability to see **UHC HPN**'s Medicaid members. The language also stated that a provider may have other health plan contracts and see members across commercial, exchange, Medicare, and Medicaid lines of business. Therefore, a calculation was used that accounted for only a portion of the provider's time as being available for **UHC HPN**'s members; if **UHC HPN** had used a full FTE calculation, it would have overinflated the ratio and the access to the provider's members. Any deficiencies meeting these requirements were submitted to DHCFP in the state-specific 402/407 report format.
  - For the time or distance standards, **UHC HPN** calculated travel time or distance, as required by DHCFP, using usual travel (i.e., in a direct route to travel from the member's home to the provider location). Members listed as homeless or with PO Boxes on the 834 file were excluded from the time or distance network adequacy calculations. **UHC HPN** advised that most of its homeless population resides in shelters in the center of its service areas and, therefore, had a high availability of providers. **UHC HPN** estimated approximately 5 percent of its membership fell within these exclusion categories. DHCFP's guidance was to exclude displaced members.
  - **UHC HPN** defined "pediatric population" as ages 0 to 21 years and "adult population" as 21 years and older when calculating time or distance standards.
- **UHC HPN** validated the member and provider counts extracted from the core system data sources up against the counts that were imported into Quest Analytics software. The queries used included data validation rules that only captured active member and provider data. Fallout error reports were automatically generated, were reviewed and checked for validity, and were rerun if significant changes were seen.
- **UHC HPN** conducted data reasonability checks by comparing each network adequacy report month over month, verified the accuracy of the updated queries/codes by comparing results of the new queries with those of established reports, and confirmed the updates maintained or improved data integrity and performance.
- **UHC HPN** maintained network adequacy indicator reports by saving the reports in its shared network drives and labeling them with the applicable network adequacy reporting period.
- **UHC HPN** conducted quality checks and data validation through Network Operations Management's review of the network adequacy reporting programs and attestations provided by Provider Services Leadership to ensure accuracy and completeness.
- To ensure continuity of network adequacy indicator production, **UHC HPN**'s Network Operations team had two backup programmers and developers who were trained and capable of supporting the network adequacy reporting requirements. Additionally, policies and procedures were maintained and reviewed annually to ensure compliance with DHCFP's network adequacy reporting requirements.
- HSAG assessed documented processes and programming language used to inform indicator-specific calculation of provider-to-member ratios, which demonstrated alignment with DHCFP-defined calculation and reporting requirements.

- HSAG assessed documented processes and programming language used to inform indicator-specific calculation of time or distance standards, which demonstrated that **UHC HPN** had reported specialty provider categories with the adult and pediatric populations combined, whereas DHCFP required the MCOs to report specialty provider categories for the adult and pediatric populations separately for a subset of provider categories. **UHC HPN** recalculated using the required accurate parameters and provided HSAG with a revised reporting template capturing results that aligned with DHCFP's required population stratification.

HSAG identified no concerns with **UHC HPN**'s network adequacy indicator reporting processes.

Assessment of Data Validity

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

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

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

☒ Acceptable

☐ Not acceptable

Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each plan according to Table 20.

Table 20—Indicator-Level Validation Rating Categories

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

Below summarizes network adequacy indicators resulting in a *Low Confidence* or *No Confidence* designation.

- No identified indicators in scope of review obtained a *Low Confidence* or *No Confidence* rating determination.

Analysis and Conclusions

HSAG determined that the providers per 1,500 members in Clark and Washoe counties exceeded DHCFP's requirements. Results are presented by the number of providers per 1,500 members in Clark and Washoe counties by DHCFP's required provider categories in Table 21.

Table 21—United Healthcare Health Plan Provider-to-Member Ratios by Provider Type by County

Provider Type	Indicator	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
PCP not practicing in conjunction with healthcare professional*	1:1,500	2.42	6.81
Specialists	1:1,500	2.65	10.98

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

DHCFP established a 100 percent threshold when determining compliance with time or distance standards. HSAG determined that indicators that fell below the 100 percent threshold achieved greater than or equal to 96.8 percent. Results are presented by percentage of members with access across Clark and Washoe counties by provider type in Table 22. Results that achieved the 100 percent access threshold are shaded green^.

Table 22—United Healthcare Health Plan Percentage of Members With Access by Provider Type by County

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Primary Care, Adults	10 miles or 15 minutes	99.9%	99.9%
OB/GYN (Adult Females)	10 miles or 15 minutes	99.9%	96.8%
Pediatrician	10 miles or 15 minutes	99.9%	99.6%
Endocrinologist	40 miles or 60 minutes	100%^	100%^
Endocrinologist, Pediatric	40 miles or 60 minutes	100%^	100%^
Infectious Disease	40 miles or 60 minutes	100%^	100%^
Infectious Disease, Pediatric	40 miles or 60 minutes	100%^	100%^
Rheumatologist	40 miles or 60 minutes	100%^	100%^
Rheumatologist, Pediatric	40 miles or 60 minutes	100%^	100%^
Oncologist/Radiologist	40 miles or 60 minutes	100%^	100%^
Oncologist/Radiologist, Pediatric	40 miles or 60 minutes	100%^	100%^
Oncologist—Medical/Surgical	30 miles or 45 minutes	100%^	100%^
Oncologist—Medical/Surgical, Pediatric	30 miles or 45 minutes	100%^	100%^
Psychologist	30 miles or 45 minutes	100%^	100%^
Psychologist, Pediatric	30 miles or 45 minutes	99.9%	100%^
Psychiatrist	30 miles or 45 minutes	100%^	100%^
Board Certified Child and Adolescent Psychiatrist	45 minutes or 30 miles	100%^	100%^

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Qualified Mental Health Professional (QMHP)	30 miles or 45 minutes	100%^	100%^
QMHP, Pediatric	30 miles or 45 minutes	100%^	100%^
Hospital, All	30 miles or 45 minutes	100%^	100%^
Psychiatric Inpatient Hospital	30 miles or 45 minutes	99.9%	99.9%
Dialysis/End Stage Renal Disease (ESRD) Facility	30 miles or 45 minutes	99.9%	100%^
Pharmacy	10 miles or 15 minutes	99.9%	99.8%

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths

Strength #1: UHC HPN had established robust processes to mitigate missing or incomplete provider information by its comprehensive contracting and credentialing processes. Additionally, **UHC HPN** has several methods of maintaining and updating provider demographic information, ensuring it is accurate and up to date for its Medicaid membership's access and availability.

Opportunities for Improvement and Recommendations

Opportunity #1: Provider network information is manually loaded from eVIPS to the Facets claims system by system analysts.

Recommendation: Although **UHC HPN** had quality assurance checks and validations in place, HSAG recommends **UHC HPN** explore options to have the data automatically or systemically uploaded from one system to another to mitigate the potential for human data entry error.

Opportunity #2: UHC HPN adjusted its calculation methodology for provider-to-member ratio reporting based on its interpretation of DHCFP contract language.

Recommendation: HSAG recommends **UHC HPN** reach out to DHCFP to confirm the DHCFP-required methodology to calculate these network adequacy indicators.

Opportunity #3: Although **UHC HPN** was able to apply the necessary corrections for final reporting, HSAG observed **UHC HPN** was not separating the adult and pediatric populations for a subset of provider categories as well as not reporting inpatient psychiatric hospitals separately as required by DHCFP.

Recommendation: HSAG recommends that **UHC HPN** work with DHCFP on future template updates to ensure all DHCFP reporting requirements are captured on the reporting template, including the population stratifications. In addition, HSAG recommends conducting a quarterly review of DHCFP reporting requirements and building in additional layers of validation to ensure logic and parameters used to inform calculations are in alignment. In addition, HSAG recommends that **UHC HPN** ensure internal process flows are documented to reflect changes year over year.

Progress Made From Prior Year

This section is intentionally not completed since this is the first year a NAV audit, in alignment with CMS EQR Protocol 4, was conducted for **UHC HPN** in Nevada. During future reporting cycles, HSAG will incorporate an evaluation of each MCE's network adequacy standards progress made from the prior year.

Programwide Results

Analysis and Conclusions

HSAG assessed the MCOs' provider-to-member ratios and determined that all Nevada MCOs exceeded DHCFP's requirements. Results across all MCOs by provider type and by county are presented in Table 23.

Table 23—Provider Ratios by Provider Type, County, and MCO

Provider Category		Nevada MCOs			
	County	Providers per 1,500 Members (Anthem)	Providers per 1,500 Members (UHC HPN)	Providers per 1,500 Members (Molina)	Providers per 1,500 Members (SilverSummit)
PCP not practicing in conjunction with healthcare professional*	Clark	13.66	2.42	7.73	17.65
	Washoe	46.55	6.81	13.37	33.40
Specialists	Clark	137.81	2.65	39.47	97.89
	Washoe	296.56	10.98	81.55	263.03

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

HSAG assessed the MCOs' submitted time or distance reports and found commonality among the MCOs that met the 100 percent threshold for time or distance requirements by provider type and by county. Results are presented in Table 24.

Table 24—Provider Categories by County That Met 100 Percent Threshold Across All MCOs

Provider Category	County	Nevada MCOs			
		Anthem	UHC HPN	Molina	SilverSummit
Endocrinologist	Washoe	100%	100%	100%	100%
Endocrinologist, Pediatric	Washoe	100%	100%	100%	100%
Infectious Disease	Washoe	100%	100%	100%	100%
Infectious Disease, Pediatric	Washoe	100%	100%	100%	100%
Rheumatologist	Washoe	100%	100%	100%	100%
Rheumatologist, Pediatric	Washoe	100%	100%	100%	100%
Oncologist/Radiologist	Washoe	100%	100%	100%	100%

Provider Category	County	Nevada MCOs			
		Anthem	UHC HPN	Molina	SilverSummit
Oncologist/Radiologist, Pediatric	Clarke	100%	100%	100%	100%
Oncologist/Radiologist, Pediatric	Washoe	100%	100%	100%	100%
Qualified Mental Health Professional (QMHP)	Washoe	100%	100%	100%	100%
QMHP, Pediatric	Clarke	100%	100%	100%	100%
QMHP, Pediatric	Washoe	100%	100%	100%	100%
All Hospitals	Washoe	100%	100%	100%	100%

HSAG assessed the MCOs' submitted time or distance reports and found commonality among the MCOs that fell below the 100 percent threshold for time or distance requirements by provider type and by county. Results are presented in Table 25.

Table 25—Provider Categories by County That Fell Below the 100 Percent Threshold Across All MCOs

Provider Category	County	Nevada MCOs			
		Anthem	UHC HPN	Molina	SilverSummit
Primary Care, Adults	Clark	99.9%	99.9%	99.9%	99.9%
Primary Care, Adults	Washoe	99.7%	99.9%	99.6%	99.6%
OB/GYN (Adult Females)	Clark	99.6%	99.9%	99.6%	99.9%
OB/GYN (Adult Females)	Washoe	99.7%	96.8%	96.2%	99.5%
Pediatrician	Clark	99.9%	99.9%	99.9%	99.9%
Pediatrician	Washoe	99.7%	99.6%	99.7%	99.7%
Psychiatric Inpatient Hospital	Clark	99.9%	99.9%	99.9%	99.9%
Pharmacy	Clark	99.9%	99.9%	99.9%	99.9%
Pharmacy	Washoe	99.7%	99.8%	99.7%	99.7%

HSAG assessed **LIBERTY**'s provider-to-member ratios and determined that it exceeded DHCFP's requirements. Results for **LIBERTY** are presented by the number of providers per 1,500 members in Clark and Washoe counties by DHCFP's required provider category in Table 26.

Table 26—LIBERTY Provider-to-Member Ratio by Provider Category and County

Provider Category	Indicator	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
Dental PCP	1:1,500	1.16	1.43

HSAG assessed **LIBERTY**'s submitted time or distance reports and found that **LIBERTY** fell below the 100 percent threshold by county for all provider categories except for Endodontist in Washoe County, which met the 100 percent threshold, and is shaded in green^. Results are presented in Table 27.

Table 27—LIBERTY Percentage of Members With Access by Provider Type by County

Provider Category	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
General Dentist	99.9%	99.9%
Dentist, Pediatric	99.9%	99.9%
Endodontist	99.9%	100%^
Periodontist	99.9%	0%
Prosthodontist	99.9%	0%
Oral Surgeon	99.9%	99.9%
Dental Hygienist	99.9%	99.9%
Dental Therapist*	NA	NA

*NA: DHCFP granted an exception for reporting the Dental Therapist provider category due to no known dental therapists servicing the area.

Strengths, Opportunities for Improvement, and Recommendations

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

Strengths

Strength #1: The MCOs had established robust oversight and validation processes to ensure completeness and accuracy in member enrollment and eligibility data processing.

Strength #2: LIBERTY had established robust processes to keep provider data up to date and accurate through its quarterly provider directory validation, credentialing process, and monthly monitoring of the multiple sanction/exclusion lists.

Opportunities for Improvement and Recommendations

Opportunity #1: Although DHCFP standards define expectations for some specialty provider categories to be reported separately for the adult and pediatric populations, the 402 reporting template provided by DHCFP to the MCOs did not provide the option to report population breakouts for the adult and pediatric populations separately.

Recommendation: HSAG recommends that DHCFP update the 402 reporting template to accurately reflect the desired population stratification breakouts for those specialty providers. Additionally, HSAG recommends that DHCFP update instructions within the template to ensure guidance is clear regarding how to determine which providers may be included in the reporting for each population (e.g., how to determine inclusion of providers that serve both an adult and pediatric population).

Opportunity #2: Definitions of the age range for the pediatric population varied between the MCOs. Some MCOs defined the pediatric population as ages 0 to under 18 years and some define it as ages 0 to under 21 years.

Recommendation: HSAG recommends that DHCFP provide the MCOs with a clear definition of the pediatric age range to be used when reporting the pediatric population.

Opportunity #3: Although the MCEs used an internally maintained provider specialty crosswalk and taxonomies to determine the required provider types, DHCFP did not define the taxonomies the MCEs should use to inform reporting. In addition, DHCFP did not have clear definitions for how to include providers who practice under more than one specialty and/or service different populations for network adequacy reporting.

Recommendation: HSAG recommends that the MCEs establish clear guidance and criteria on provider type classification and population breakouts to mitigate variation in MCE-reported results.

Opportunity #4: HSAG observed variations in how MCEs determined compliance for the GeoAccess standards in scope of review. Specifically, **SilverSummit** and **UHC HPN** generated separate output reports – one for time and one for distance; however, did not indicate which parameter was used to determine compliance with the standard.

Recommendation: HSAG recommends DHCFP define criteria and expectations for determining and reporting compliance with the "Or" method. In addition, HSAG recommends DHCFP update the 402 reporting template to capture the percentage of members with access, method for determining compliance (e.g., "Time" or "Distance"), and compliance status.

Progress Made From Prior Year

This section is intentionally not completed since this is the first year a NAV audit, in alignment with CMS EQR Protocol 4, was conducted for the MCEs in Nevada. During future reporting cycles, HSAG will incorporate an evaluation of programwide network adequacy standards progress made from the prior year.

Appendix A. HSAG Validation Team and List of Interviewees

Table A-1 lists the **Anthem** staff members interviewed by the HSAG validation team.

Table A-1—List of Anthem Interviewees

Interviewee Name	Title
Joy Thomas	Regional Vice President (VP) II and President, Medicaid Health Plan
Beth Maldonado	Director II Compliance
Karla Lawson	Director Program Management, Provider Data
Jim Price	Government Business State Operations Director, Medicaid Operations
Carrie Young	Manager II Enrollment Data, Enrollment and Billing
Kelsi Richards	Business Change Manager, Provider Contracting
Dominic Gaon	Provider Network Manager Senior, Provider Contracting
Abigail Roa Justiniano	Director II Compliance
Terri Piechocki	Account Management Executive Advisor, IT
Vanessa Santos	Provider Data Intake Analyst I, Provider Data
Franchesca Radcliffe	Compliance Manager, Enterprise Audit Support
Zida Ash	Systems Analyst Advisor, Provider Contracting
Abhilash Reddy Pilla	Engineer Lead, Regulatory Reporting
Eddie Duckworth	Manager II Engineering, Regulatory Reporting
Beth Lamper	Director I Compliance, Enterprise Audit Support
Shubhangi Goyal	Business Analyst III, Regulatory Reporting
JoEllen Scheid	Manager II Credentialing
Latoya Vaughn	Business Info Consultant Senior, Provider Data

Table A-2 lists the **LIBERTY** staff members interviewed by the HSAG validation team.

Table A-2—List of LIBERTY Interviewees

Interviewee Name	Title
Tricia Schares	Assistant Vice President (AVP), Network Management
Doug Stewart	Manager, Compliance

Interviewee Name	Title
Lory England	Director, Eligibility Enrollment
Matthew VanderWall	Manager, Electronic data interchange (EDI) Eligibility
Tom Mergan	AVP, IT Applications
Samual Green	Manager, Provider Relations Analytics
Bre Stark	VP State Markets
Brandon Cable	VP IT Infrastructure
David Bird	AVP Provider Operations
Isaac Appiah	Director, Information Security Risk and Compliance
Candice Kenar	Senior Compliance Analyst
Tao Zhou	Manager, IT Security and Compliance
Tod Kemper	Principle Cyber Security Architect

Table A-3 lists the **Molina** staff members interviewed by the HSAG validation team.

Table A-3—List of Molina Interviewees

Interviewee Name	Title
Reagan Virgil	Auditor, External Compliance
Michael Polston	Compliance Officer
Flavio Arellano	Senior Program Manager, External Compliance
Sara Cooper	Vice President, Network Management & Operations
Alicia Simmons Lewis	Senior Business Analyst
Ryan Williams	Director, IT Business Relationship Management
Nagesh Pantula	Director, Applications
Thomas Buvia	Manager, Business Continuity
James Embra	Senior Specialist, Government Contracts
Philip Ramirez	Assistant Vice President, Government Contracts
Mamta Ojha	Manager, Operations
Kyle Brandel	Manager, Data Analytics
Jonathan Adkins	Director, Provider Network Management
Rob Baughman III	Plan President
Carrianne Dockter	Director, Credentialing
Tanner Johnson	Manager, Credentialing

Interviewee Name	Title
Colin Hunter	Director, Provider Data Management (PDM)
Kelly Hempstead	Assistant Vice President, Core Operations
Lori Bergen	Manager, Enrollments
Victoria Williams	Director, Enrollments
Jamie Dudgeon	Director, Enrollments
Bhawna Joshi	Analyst, Operations Regulatory Oversight
Stephen Weber	Assistant Vice President, Information Services
Manny Bugayong	Assistant Vice President, Information Security
Amber Wilkins	Senior Specialist, Government Contracts
Michael Weber	Assistant Vice President, Network Strategy & Services
James Graham	Program Manager

Table A-4 lists the **SilverSummit** staff members interviewed by the HSAG validation team.

Table A-4—List of SilverSummit Interviewees

Interviewee Name	Title
Sarah Fox	Vice President, Network Development & Contracting
Allyson Hoover	Director, Network Development Maintenance
Yesenia Serrano	Manager, Provider Data
Bonnie Nichols	Business Analyst IV
Ron Tilley	Lead IT Assurance Analyst
Francesca Douglas	Senior Manager, Enrollment
Srividya Uppalapati	Business Analyst I
Christine Hall	Senior Director, Reporting & Business Analysis
Shirish Limaye	Vice President, Operations
Tracey Argentieri	Senior Manager, Provider Network Management Operations
Jason Dolvin	Project Manager
Susan Furch	Director, Enrollment
Julia McLeod	Manager, PDM & Credentialing
Katie Muller	Business Analyst III
Cathryn Spinney	Business Analyst II
Ed F. De Guzman	Senior Storage Engineer

Interviewee Name	Title
Eric Schmacker	Plan President, CEO
Keri Kelley	Compliance Officer
Audrey Ponce	Compliance Analyst
Crystal Joy Rosano	Compliance Specialist

Table A-5 lists the **UHC HPN** staff members interviewed by the HSAG validation team.

Table A-5—List of UHC HPN Interviewees

Interviewee Name	Title
Josh Coello	Associate Director of Network Contracting
Shawna Reed	Director of Provider Services
Juneil Williams	Enrollment/Eligibility Manager
Josh Taylor	Associate Director of Business Process
Richard Connor	Senior Software Engineer
Travis O'Connor	Director of Tech Project & Program Management
Shawna DeRousse	Director of Compliance
Seth Wray	Compliance Consultant
Deanna Heisey	Manager of Credentialing
Kathleen Robinson	Manager of Provider Data
Herbert Alquisada	Senior Business Analyst
Heidi Kanellis	Associate Director of Employer Install

Table A-6 lists the HSAG validation team members, their roles, and their skills and expertise.

Table A-6—HSAG Validation Team

Name and Title	Role
Elisabeth Hunt, MHA, CHCA *Executive Director, Data Science & Advanced Analytics (DSAA)*	Certified Healthcare Effectiveness Data and Information Set (HEDIS®)[2] Compliance Auditor (CHCA); multiple years of auditing experience with expertise in data integration, information systems, provider data, NAV, and performance measure development and reporting.

[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Name and Title	Role
Rachael French, CHCA *Director, Audits, DSAA*	CHCA; subject matter expertise in managed care, quality measure reporting, quality improvement (QI), performance measure knowledge, data integration, systems review and analysis, provider data, and NAV. Multiple years of auditing experience.
Cynthia Anderson, MPH *Analytics Manager III, DSAA* *Project Lead*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
Arpi Dharia, MBA *Auditor III, DSAA* *Task Lead/Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.
Kerry Wycuff, BS *Auditor I, DSAA* *Lead Auditor*	Subject matter expertise in managed care, quality measure reporting, QI, performance measure knowledge, data integration, systems review and analysis, and NAV.

Appendix B. Network Adequacy Validation Worksheets

Appendix B contains a single ZIP file for all NAV specific validation worksheets, which includes Microsoft Excel workbooks with the MCEs' final validation ratings for each network adequacy indicator in scope of review. The validation rating determinations are based on the MCEs' submitted documentation from the 2024 NAV audit activities.