415 - PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN

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Effective Date: 06/01/10; 10/01/11, 12/01/11, 11/01/12, 10/01/13
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Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care, Behavioral Health Services (BHS), Arizona Long Term Care Elderly and Physically Disabled System (ALTCS/EPD), Children's Rehabilitation Services (CRS), Comprehensive Medical and Dental Program (CMDP) and ALTCS Division of Developmental Disabilities (DDD) Contractors. It is critical for Contractors to develop and maintain a provider network that is sufficient to provide all covered services to AHCCCS members. Provider networks must be a foundation that supports an individual's needs as well as the membership in general.

II. Definitions

GSA Geographic Service Area: A specific county or defined grouping of counties designated by AHCCCS within which a Contractor provides, directly or through subcontract, covered health care to members enrolled with that Contractor.

Provider Any person or entity (including Tribal/Regional Behavioral Health Authorities) who contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

III. Policy

The Contractor shall develop and maintain a provider network development and management plan, which assures the Administration that the provision of covered services will occur as stated in the contract [42 CFR 438.207(b)]. The Network Development and Management Plan must be evaluated; updated and submitted to AHCCCS, Division of Health Care Management, within 45 days from the start of each contract year.

The Contractor shall immediately notify AHCCCS in writing when there has been a significant change in operations that would affect adequate capacity and services. The changes include, but are not limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population.

Contractors must submit the Network Attestation form (Attachment A) in conjunction with the annual submission of the Network Development and Management Plan. See Attachment A-1 for instructions on completing the form.

Submitted via electronic mail to your:

Operations and Compliance Officer (or her/his designee)
AHCCCS, Division of Health Care Management
701 E. Jefferson, Mail Drop 6100
Phoenix, AZ 85034

IV. Procedure

The Network Development and Management Plan shall include the Contractors process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
The items below apply to all Contractors, with the exception of the items in bolded parenthetical notation. The items in bolded parenthetical notation are Contractor specific and only apply to those Contractors listed.

The Plan must include the process the Contractor utilizes to ensure:

1. That covered services are accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those are to non-AHCCCS persons within the same service area.
2. That covered services are provided promptly and are reasonably accessible in terms of location and hours of operation.
3. That there shall be sufficient personnel for the provision of all covered services, including emergency care on a 24 hour a day, seven day a week basis.
4. (**ALTCS EPD, DDD and BHS**): A priority shall be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institution or alternative residential setting. To that end the development of home and community based services shall include provisions for the availability of services on a 7 day a week basis, and for extended hours, as dictated by member needs.

The plan must also include a description or explanation of the following:

1. Evaluation of the prior year's Plan including reference to the success of proposed interventions and/or the need for re-evaluation.
2. Current status of the network by service type (Hospital, Nursing Facility, HCBS, Primary Care OB/GYN, Specialist, Oral Health, Non Emergent Transportation, Ancillary Services, etc.) at all levels including:
    a. How members access the system
    b. Relationships between the various levels (focus on provider to provider contact and facilitation of such by the Contractor; e.g. PCP, Specialists, Hospitals, T/RBHAs)
3. Current network gaps and the methodology used to identify them.
4. Immediate short-term interventions when a gap occurs, including expedited or temporary credentialing.
5. Interventions to fill network gaps and barriers to those interventions.
6. Outcome measures/evaluation of interventions.
7. Ongoing activities for network development based on identified gaps and future needs projection.
8. Coordination between internal departments; including a comprehensive listing of all committees and committee membership where this coordination occurs. Identification of members should include the department/area (i.e., QM, MM/UM, GRV, FIN, CLAIMS) that they represent on the committee.
9. Coordination with outside organizations; (**ALTCS EPD, DDD and CRS** Contractors shall address member/provider/parent council activities).
10. A description of network design by GSA for the general population, including details regarding special populations. [**Acute, CMDP, CRS and BHS** Contractors shall understand these populations to include the physically and cognitively impaired (Arizona Early Intervention Program (AzEIP)), the homeless and those in border communities; among others. **ALTCS EPD, DDD** Contractors shall understand these populations to include behavioral health; young adults and children; among others.] The description shall cover:
    i. How members access the system
    ii. Relationships between various levels of the system
    iii. (**Acute, CMDP, CRS and Behavioral Health)** a listing/description of the available alternatives to Nursing Facility placement such as Assisted Living Facilities, alternative residential settings, or home and community based services (minimum one listed per GSA) as required by contract. A similar requirement exists on a larger scale under number 17 of the ALTCS Only listing. If the Contractor requires additional information on procuring such services, they shall contact the ALTCS Contractor in the GSA for assistance in identifying available alternatives
    iv. (**Acute, CMDP and CRS**) the plan for incorporating the medical home for members and the progress in its implementation

v. (**ALTCS EPD and DDD**) the description shall include a list of these providers along with a description of services provided by the program and projected utilization

11. (**Acute, CMDP, CRS , ALTCS EPD and DDD**) A description of the adequacy of the geographic access to tertiary hospital services for the Contractor's membership.
12. (**Acute, CMDP and CRS**) The assistance provided to PCPs when they refer members to specialists. The methods used to communicate the availability of this assistance to the providers
13. (**Acute, CMDP and CRS**) An analysis of the Contractors Appointment Availability Report statistics as set forth in ACOM Policy 417.
14. The methodology(ies) the Contractor uses to collect and analyze member, provider staff and other stakeholder feedback about the network designs and performance. When specific issues are identified, the protocols for handling them.
15. (**Acute, CMDP and CRS**) If the Contractor does not have contracts with hospitals, they must contract with physicians with hospital admitting and treatment privileges, Attachment B (Non-Contracted Hospital and Physician Admitting and Treatment Privileges) of this policy must be submitted annually.

(For **ALTCS EPD and DDD Contractors Only**)

16. Listing of non-Medicare Certified Home Health Agencies the Contractor is using. The listing is to be provided on the form distributed by AHCCCS and attached to the Plan. (AMPM Policy 1240) (See Attachment A).
17. The strategies the Contractor has for Work Force Development. Contractors make up the largest payer group for paraprofessionals in the long term care market and must leverage this to ensure adequate resources in the future. Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership. The Contractor must have as part of their network development plan a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home (attendant care, personal care and homemaker). Work Force Development is defined as all activities that increase the number of individuals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. Contractor supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care.
18. Strategies the Contractor will take to provide members with “in-home” HCBS versus placing members in Assisted Living Facilities and Nursing Facilities. A priority shall be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institutional or alternative residential setting.

19. (**ALTCS EPD**) A Contractor must include the specific pro-active strategies/actions they will take to reduce the percentage of HCBS members in Alternative Residential Settings once 20% or more of its HCBS membership resides in Alternative Residential Settings. If any GSA served by the Contractor is currently greater than 20%, the Contractor must demonstrate the implementation of its strategies/actions.
20. A listing of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval. (See Attachment C)
21. A listing of nursing facilities that have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility. (See Attachment C)
22. Description of how the Contractor will handle the loss (closure, contract termination) of a major healthcare provider (hospital, nursing facility, large provider group).
23. A description of the methods the Contractor will use to ensure that ALTCS members receive needed services in the event of a natural disaster.

The plan must include answers to the following questions:

a. (**Acute, CMDP and CRS**) How does the Contractor assess the medical and social needs of new members to determine how the Contractor may assist the member in navigating the network more efficiently?
b. (**Acute, CMDP and CRS**) What assistance is provided to members with a high severity of illness or higher utilization to better navigate the provider network?
c. (**Acute, CMDP and CRS**) How does the Contractor support the Graduate Medical Education (GME) programs within its contracted GSA(s) and pursue contracting opportunities with graduates and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas?
d. (**Acute and CMDP**) Describe the Contractor's process to increase provider participation in Baby Arizona.
e. What interventions has the Contractor implemented to reduce avoidable/preventable ER utilization? What was the outcome of those interventions?
f. (**Acute, CMDP, CRS , ALTCS EPD and DDD**) Are members with special health care needs assigned to specialists for their primary care needs? If so, what general criteria are used to determine if a member should be assigned in this manner?
g. What are the most significant barriers to efficient network deployment within the Contractor's service area? How can AHCCCS best support the Contractor's efforts to improve its network and the quality of care delivered to its membership?
h. (**Acute, CMDP, CRS , ALTCS EPD and DDD**) What interventions has the Contractor implemented to address and reduce no-show rates and how is information collected to assess the efficacy of these measures?
i. (**Behavioral Health**) How are members with chronic medical conditions identified within the T/RBHA system record keeping mechanism and how are placement options coordinated with/communicated to Acute Care Contractors?

V. Provider Terminations Due to Rates (Quarterly Submission)

The Contractor will submit to their AHCCCS Compliance Officer a report of providers who have terminated their contract due to rates 15 days following the end of each quarter using the report template attached (Attachment D) to this policy. Submission of Attachment D for each GSA is required even when the Contractor does not have any terminations to report.

The report will consist of the following information regarding all providers who terminate their contracts for rate related reasons during the reporting period by GSA:

Provider Name	The name of the provider leaving the network. If a provider group has terminated their contract, each provider in the group should be listed separately.
Provider ID Number	The 6-digit AHCCCS legacy identification number. Do not use a provider's NPI.
Provider Type	The Provider Type code as utilized in PMMIS.
PCP	'Y' yes or 'N' no (Is defined as a 08-MD, 31-DO, 19-NP, 18-PA; responsible for the management of a member's health care)
Provider Capacity	This column should be populated with the number of members assigned to, residing in, or regularly receiving services from the provider. In the case of hospitals, outpatient facilities, labs, etc. indicate the number members (unduplicated) that on average utilize the providers during the three month time period prior to the termination date. In the case of nursing facilities and alternative residential settings indicate the number of members residing in the facility at the time of termination notice by the provider.
Reason for Termination	Insert one of the following reasons: • Increased rate requested (provider initiated) • AHCCCS FFS rate reduction (pass-through) • Contractor rate reduction (not associated with an AHCCCS reduction) • Other (Use only if the termination reason does not fall under one of the first three bullets and ***is a rate related*** reason. Describe using only a ***rate related reason***.)
Attestation	Include a statement if the loss of the provider will result in a network gap. If there will be a gap, indicate how the Contractor will meet member needs after the provider leaves the network.

VI. Providers that Diminish their Scope of Service and/or Close their Panel (Quarterly Submission)

The Contractor will submit to their Operations and Compliance Officer a report of providers that have diminished their scope of service and/or closed their panel, 15 days following the end of each quarter using the report template attached (Attachment E) to this policy. Submission of Attachment E for each GSA is required even when the Contractor does not have any providers to report.

The report will consist of the following information regarding all providers who have diminished their scope of service and/or that closed their panel during the reporting period by GSA:

Provider Name	The name of the provider.	
Provider ID Number	The 6-digit AHCCCS legacy identification number. Do not use a provider's NPI.	
Provider Type	The Provider Type code as utilized in PMMIS.	
Scope of Service Diminished	Type of Service N/A if not applicable	
Panel Closed	'Y' yes N/A if not applicable	A) Medicaid B) Non-Medicaid
Provider Capacity	This column should be populated with the number of members assigned to, residing in, or regularly receiving services from the provider. In the case of hospitals, outpatient facilities, labs, etc. indicate the number members (unduplicated) that on average utilize the providers during the three month time period prior to the termination date. In the case of nursing facilities and alternative residential settings indicate the number of members residing in the facility.	
Reason	Insert one of the following reasons: • Increased rate requested (provider initiated) • AHCCCS FFS rate reduction (pass-through) • Contractor rate reduction (not associated with an AHCCCS reduction) • Other (Use only if the termination reason does not fall under one of the first three bullets and ***is a rate related*** reason. Describe using only a ***rate related reason***.)	
Attestation	Include a statement if the change will result in a network gap. If there will be a gap, indicate how the Contractor will meet member needs after the provider leaves the network.	

VI. References

- Title 42 of the Code of Federal Regulations (42 CFR) Part 438.200
- Acute Care Contract, Section D
- ALTCS EPD Contract, Section D
- ALTCS DDD Contract, Section D
- CMDP Contract, Section D
- CRS Contract, Section D
- ADHS\DBHS Contract, Section D

Attachment A

NETWORK ATTESTATION STATEMENT

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement

From

Contractor's Name

To The

Arizona Health Care Cost Containment System
Division of Health Care Management, Operations

- ❑ I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶28 and ¶29; CMDP Contract Section D, ¶28 and ¶29; CRS Contract Section D, ¶28 and ¶29; ALTCS EPD Contract Section D, ¶28 and ¶29; ALTCS DDD Contract Section D, ¶28 and ¶29; BHS Contract Section D ¶18; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

- ❑ I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶28 and ¶29; CMDP Contract Section D, ¶28 and ¶29; CRS Contract Section D, ¶28 and ¶29; ALTCS EPD Contract Section D, ¶28and ¶29; ALTCS DDD Contract Section D, ¶28 and ¶29; BHS Contract Section D ¶18; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

_____

(Network Administrator Signature) Date

Attachment A-1 Instructions for the Network Attestation Statement

NETWORK ATTESTATION STATEMENT

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement

From

❶ Contractor's Name

To The

Arizona Health Care Cost Containment System
Division of Health Care Management, Operations

❷❑ I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶28 and ¶29; CMDP Contract Section D, ¶28 and ¶29; CRS Contract Section D, ¶28 and ¶29; ALTCS EPD Contract Section D, ¶28and ¶29; ALTCS DDD Contract Section D, ¶28 and ¶29; BHS Contract Section D ¶18; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

❸❑ I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶28 and ¶29; CMDP Contract Section D, ¶28 and ¶29; CRS Contract Section D, ¶28 and ¶29; ALTCS EPD Contract Section D, ¶28and ¶29; ALTCS DDD Contract Section D, ¶28 and ¶29; BHS Contract Section D ¶18; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and county (ies):

_____

❹(Network Administrator Signature) ❺Date

Contractors must submit a separate Attestation for each Line of Business (LOB)

❶ Insert Contactor's name: Mercy Care Plan
Mercy Care LTC

❷ Check this box if the GSA and county you are reporting does not meet required Network Standards. Insert the Settings/Service types, GSA(s) and/or county (ies) where Network Standards are not met.

Example:

Acute LOB: GSA 4 – Apache, Mohave, Navajo: Speech/hearing Therapist

ALTCS LOB: GSA 44 - Apache County: Assisted Living Centers; Adult Day Health; Speech Therapy

❸ Check this box if the GSA and county you are reporting meets all required Network Standards. Insert the GSA number and the county (ies) meeting the Standards.

Example:

Acute LOB: GSA 4 – Coconino
GSA 12 - Maricopa

ALTCS LOB: GSA 44 - Coconino, Mohave, Navajo
GSA 52 - Maricopa

NOTE: It is possible to have both Bullet 2 and Bullet 3 boxes checked at the same time. One or more counties in a multiple GSA could be in full compliance with the Network Standards while one or more could be out of compliance.

❹ Have the appropriate Network Administrator sign the Attestation Statement

❺ Include the date the Attestation was signed

Attachment B **Non-Contracted Hospital and Physician Admitting & Treatment Privileges Attestation Statement**

I_____ affirm that _____ has contracts with physician(s) with admitting and treatment privileges at the hospitals within the communities identified below
Signature: _____ Date: _____

GSA 2
- ☐ Blythe, CA
- ☐ Lake Havasu City
- ☐ Parker
- ☐ Yuma
- ☐ GSA Not Applicable

GSA 4
- ☐ Bullhead City
- ☐ Page
- ☐ Flagstaff
- ☐ Payson
- ☐ Gallup, NM
- ☐ Show Low
- ☐ Kanab, UT
- ☐ Springerville
- ☐ Kingman
- ☐ Lake Havasu City
- ☐ Winslow
- ☐ Needles, CA
- ☐ GSA Not Applicable

GSA 6
- ☐ Cottonwood
- ☐ Flagstaff
- ☐ Maricopa County
- ☐ Prescott
- ☐ GSA Not Applicable

GSA 8
- ☐ Casa Grande
- ☐ Globe
- ☐ San Tan
- ☐ Maricopa County Dist. 4
- ☐ Payson
- ☐ GSA Not Applicable

GSA 10 (Santa Cruz Only)
- ☐ Nogales
- ☐ GSA Not Applicable

GSA 14
- ☐ Benson
- ☐ Bisbee
- ☐ Douglas
- ☐ Safford
- ☐ Sierra Vista
- ☐ Tucson
- ☐ Willcox
- ☐ GSA Not Applicable

Attachment C

NETWORK DEVELOPMENT AND MANAGEMENT REPORT

CONTRACTOR:_____**DATE:** _____

ALTCS Contract, Network Management and Development Plan paragraph requires the following items to be listed:

Non-Medicare Certified Home Health Agencies (HHA):

	Non-Medicare Certified HHA Name	AHCCCS ID#	Type of Services Provide	Geographic Area Served
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9				
10				

Use of a non-Medicare Home Health Agency(ies) is in compliance with AMPM Chapter 1200, Section 1240, ALTCS Services/Settings, Home Health Services.

List of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval:

	Assisted Living Center	AHCCCS ID#	City / Area Served	Exception Period (10-07 to 9/08)
1.				
2.				
3.				
4.				
5.				

List of nursing facilities who have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility:

	Nursing Facility	AHCCCS ID#	City / Area Served	Number of Residents
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Attachment D

Provider Terminations Due to Rates

Contractor Name: Date:

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	PCP	Provider Capacity	Reason for Termination	Attestation

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	PCP	Provider Capacity	Reason for Termination	Attestation

Attachment E

Providers that Diminished their Scope of Service and/or Closed their Panel

Contractor Name: Date:

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	Scope of Service Diminished	Panel Closed		Provider Capacity	Reason	Attestation

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	Scope of Service Diminished	Panel Closed		Provider Capacity	Reason	Attestation