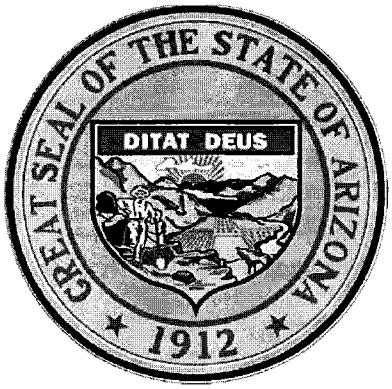

PROPOSAL TO ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

IN RESPONSE TO TASK ORDER # YH18-0031 ANALYSIS OF PROP 206 IMPACT ON PROVIDER NETWORK ADEQUACY

BURNS & ASSOCIATES, INC.

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SEPTEMBER 28, 2017

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Delivered via email to Michael.Kowren@azahcccs.gov

September 28, 2017

Mr. Michael Kowren
Procurement Specialist
AHCCCS Procurement Office
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

Dear Mr. Kowren:

Burns & Associates, Inc. is pleased to submit this response to Task Order #YH18-0031 *Analysis of Prop 206 Impact on Provider Network Adequacy*. We are submitted our bid under the conditions set forth in our contract as an AHCCCS Health Care Financial Consultant, Contract # AHCCC16-098674, YH14-0033-03, Amendment #3 dated December 29, 2016.

Burns & Associates believes that with our recent experience working with two other State Medicaid Agencies on similar engagements, in conjunction with our extensive understanding of HCBS services delivered by Arizona providers, particularly for Arizona DDD, we are well poised to deliver to AHCCCS a comprehensive report under the tight project timeline.

There is nothing in the contents of this bid that Burns & Associates deems to be proprietary or confidential. As President of the firm, my signature commits Burns & Associates to the contents of this proposal. I will serve as the single point of contact for clarification of information. My contact information is listed below:

Burns & Associates, Inc.
mpodrazik@burnshealthpolicy.com
Mobile: (703) 785-2371

We appreciate your consideration.

Sincerely,

Mark A. Podrazik
President

EXPERIENCE AND CAPACITY

Burns & Associates (B&A) believes that it is well-suited to perform the work requested in this task order given our experience working on multiple projects similar in scope in just the past few years. The team that is being proposed has all performed the functions for which they will be assigned on this project on many similar projects for State Medicaid Agencies. Additionally, we believe that B&A's in-depth institutional knowledge of Arizona DDD's service array and provider base, in conjunction with our 15+ years of experience setting rates for DDD, will provide additional value to this engagement. Our office location in downtown Phoenix will also assist in efficiently administering the project and will provide the option to schedule ad hoc in-person meetings with AHCCCS, if needed, in addition to the meetings that have already been scheduled in the work plan.

Relevant Project Qualifications

In its 11 year history, B&A has worked with **31 state agencies in 24 states**: Arizona, California, Connecticut, Georgia, Illinois, Indiana, Louisiana, Maine, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Texas, Vermont and Virginia. We have also done work for the Canadian province of Alberta and for the Medicaid and CHIP Payment and Access Commission (MACPAC).

For the tasks that will be required for this scope of work, B&A has completed nine projects among eight State Medicaid clients in the last five years that are relevant. A summary of this experience appears in the matrix on the next page. With respect to the five independent evaluations cited in the matrix, all of them have been completed in the last 18 months. Additionally, the B&A Project Manager assigned to this engagement wrote independent evaluations for three other state clients (Minnesota, New York and Oklahoma) and assisted writing a fourth evaluation (Nevada).

After the matrix, we present case studies for some of the projects that are listed. The remainder of this section introduces the project team. Resumes for all proposed team members appear in Appendix A. B&A is not proposing any subcontractors to work on this engagement. All team members are full-time employees of B&A. The project team proposed is prepared to start work October 6, 2017 and has the bandwidth to complete their assignments in the work plan in order to meet the deadline to deliver the report by January 2, 2018.

Matrix of Burns & Associates, Inc. Experience Related to this Project Scope of Work

Clients Where Task Has Been Completed in the Last Five Years

Task Applicable to this Project	Indiana OMPP - Annual EQR	Indiana OMPP - Independent Assessment	Ohio Department of Medicaid	Vermont Department of Health Access	New Mexico DDSD	Arizona DDD	Virginia DBHDS	Hawaii DDD	Oregon DDD
Conduct MCO provider adequacy study	x								
Conduct provider access study	x	x							
Conduct provider rate study / set rates where wages informed final rates			x	x	x	x	x	x	x
Conduct desk review of MCO or ACO policies and procedures	x	x		x					
Facilitate meetings with MCO or ACO representatives	x		x	x					
Map unique services to providers using claims/encounters	x	x	x	x	x	x	x	x	x
Compile comparative utilization statistics (e.g., usage rates, per 1,000 members, etc.)	x	x	x	x	x	x	x	x	x
Utilize Google Distance Matrix or BING to derive driving distances	x	x	x				x	x	x
Create data visualization maps (e.g., provider coverage areas, avg driving distances)	x	x	x		x		x	x	x
Conduct provider survey	x			x	x	x	x	x	x
Write independent evaluation report*	x	x	x	x		x			

*Other states for which independent evaluation reports have been written (but not in the last five years) include Minnesota, Nevada, New York and Oklahoma.

Project Case Study: Arizona Department of Economic Security, Division of Developmental Disabilities (DDD)

Since its founding, B&A has assisted the DDD on a wide variety of operational activities and strategic planning, most significantly related to the Published Rate System[1] utilized for its HCBS service array. B&A's founders also both participated in these activities with DDD going back to 2001 (while employed at another consulting firm). Most recently, B&A was instrumental in the rate setting activities completed in fiscal year 2014. Additionally, B&A has been supporting DDD with an annual review of the 'adequacy and appropriateness' of the rates utilized by DDD for services provided to its members though an Annual Rate Certification Letter.

During the most recent rate setting activities, B&A (in cooperation with another firm) provided the framework for the development of the updated independent rate models for approximately thirty major home and community based services, including most of the services outlined within this project. B&A facilitated a series of focus groups with several groups of providers, administered a comprehensive provider survey and identified other benchmark data. Based on this input and data, B&A proposed changes to the cost assumptions in the existing models, including updates to direct support worker wages, benefits and productivity as well as agency overhead costs. The focus groups further illuminated DDD's (and B&A's) understanding of provider cost structures and the sensitivity to impacts on providers related to wage and benefit changes which, for most HCBS services, comprise the majority of the costs built into the rate being developed. B&A led several meetings to explain the proposed changes to the rate models and helped in the review of public comments in response to the proposals.

Once finalized, the fiscal impact of the resulting final rate models was modeled. This analysis demonstrated that the Division did not have the resources to implement these rates. In response, B&A helped to establish 'adopted rates' that were transparently established at set percentages of the 'benchmark' rates. The provider community has used this information to lobby for additional funding, which has resulted in gradual increases in these rates. Since the implementation of the revised rate structure, B&A has performed ongoing maintenance for the Published Rate System to support changes through either DDD policy changes and/or additional funding appropriated through the Arizona Legislature. Maintenance activities have included analysis and guidance on the extent to which selected services from the Published Rate System would have to be adjusted to accommodate the changes in minimum wage after voter passage of an initiative to increase the State's minimum wage.

This rate setting process has evolved in sophistication since B&A's founders worked on the original rate setting project with DDD in 2000-2001. Since the first rate setting project over 15 years ago, B&A has assisted the DDD with major rate rebase efforts in 2004, 2009 and 2014. Three of the five team members proposed for this engagement have worked on projects for Arizona's DDD.

On an annual basis, B&A provides support to DDD with an annual review of the 'adequacy and appropriateness' of the rates utilized by DDD for HCBS services. This is commonly referred to as the Rate Certification Letter (this is one of the items to be considered in this Task Order). The review includes an in-depth review of: the number of members served; number of active providers; overall utilization (units and payments); and detailed analyses of the geographic differences for professional services the DDD has identified as having historical issues to acquire. The review is guided by and measured against the principle federal tests for adequacy and appropriateness contained in Section 1932 of the Social Security Act regarding the service network for Medicaid managed care organizations. These criteria are utilized due to the fact that the DDD is deemed as a Medicaid managed care organization for AHCCCS.

[1] The DDD provides a RateBook and Supplement detailing rates and methodology for HCBS services.

Project Case Study: Indiana Office of Medicaid Policy and Planning (OMPP)

B&A has been under contract with Indiana's OMPP since 2007. Prior to this, Mark Podrazik, B&A's President, worked with the OMPP from 2001 to 2006 prior to co-founding B&A. B&A serves as Indiana's External Quality Review Organization (EQRO). B&A is under contract to conduct an annual EQR and to write a report to submit to the Centers for Medicare and Medicaid (CMS). B&A is also contracted to write an annual independent evaluation of Indiana's Children's Health Insurance Program (CHIP). In 2009, B&A also conducted an independent evaluation of Indiana's Care Select program, a non-risk based program serving the ABD population. For this evaluation, B&A conducted a member survey (n=8,595).

Another recent evaluation that B&A completed for the OMPP was an Independent Assessment of the Hoosier Care Connect program. This program is the program subsequent to Care Select that is now under a risk-based arrangement. The program was created under 1915(b) waiver authority and, as such, is subject to an independent evaluation prior to renewal of the waiver. B&A conducted this evaluation and our report was submitted to CMS in March 2017. One of the many aspects of this evaluation included a review of access to services for 19 provider specialties. For each of the specialties, B&A compared the unique providers used, utilization per 1,000 member months, and average driving distance to the specialist during the "with waiver" and "without waiver" baseline period.

In each of the annual EQRs, B&A conducts onsite meetings with each of the State's managed care entities (MCEs, which is Indiana's term for MCOs). In some years, including the last two EQRs, B&A has also facilitated meetings that convened all of the MCEs together on specific topics such as care management reporting, performance improvement projects and results of the analysis of potentially preventable hospital readmissions.

In some years, the EQR is more general in nature with the review of MCE policies and procedures. In most years, however, B&A works with the OMPP to identify focus studies. Since CY 2011, B&A has conducted 23 unique focus studies in the EQRs covering a wide range of topics including utilization management, care management, disease management, access to care, member services, provider relations, program integrity, claims processing, and potentially preventable hospital readmissions and ED visits. In the CY 2009 EQR, B&A conducted a provider survey (n=1,084).

In CY 2016, B&A conducted three focus studies relevant to this Task Order—one was an audit of MCE provider directories, a second analyzed beneficiary access to 23 provider types, and the third was a more in-depth focus on the utilization and access to dental services. The EQR report submitted to CMS that contained this study has been included as Appendix B with our response.

All five team members proposed for this engagement have worked on projects for Indiana's OMPP.

Project Case Study: Ohio Department of Medicaid (ODM)

B&A, under subcontract to Mercer, has been working with the ODM since 2011 on a variety of projects including:

- Rebase of inpatient hospital rates (new rates implemented July 2013 and again in July 2017)
- Rebase of outpatient hospital rates (new rates implemented August 2017)
- Technical assistance related to ODM's preparation to migrate to ICD-10 coding (fee-for-service and managed care programs)
- Evaluation of the impact of ICD-10 coding on hospital payments one year after implementation
- Evaluation of opportunities to streamline prior authorization functions in the fee-for-service program
- Rebase of rates paid for power wheelchairs and related components

In addition to these projects, the one most relevant to this Task Order was completed in the Spring of 2016. B&A served as the technical consultant for the analysis and development of ODM's Access to Care Plan for its fee-for-service program that was required by CMS. B&A worked hand-in-hand with ODM's Project Manager to design the elements of the analysis and the format of the data presented that will serve as the baseline for future evaluations. Through this process, opportunities were identified to improve access for the provider specialties that were examined: primary care physicians, OB/GYNs, FQHCs, dentists, specialist physicians (cardiologists, urologists and radiologists), behavioral health providers and home health agencies.

The analytics completed for the Access to Care study included analyzing the number of unique providers accessed, utilization per 1,000 member months and average distance travelled. These analytics were conducted at the provider specialty level with additional drilldowns for the adult vs. pediatric population and the disabled vs. non-disabled populations. All data was further segmented down to the individual 88 counties in Ohio. A scorecard was developed to summarize the findings in an efficient manner to identify areas of concern for provider access. A databook was created that included tables and maps that drilled down into specific data points by service/aid category/county.

Three of the five team members proposed for this engagement worked on the ODM Access to Care project.

Other Project Examples: HCBS Rate Setting

B&A has completed, or is in the process of completing, HCBS rate setting projects for State Agencies in Arizona, California, Georgia, Hawaii, Louisiana, Maine, Mississippi, New Mexico, North Carolina, North Dakota, Oregon, Rhode Island and Virginia. In all of these states, B&A has created a customized provider survey that includes in-depth data collection for staffing costs (wages and benefits) as well as program and administrative expenses. Many surveys have also included questions about how providers have responded to statutory or regulatory changes, such as ACA health insurance requirements or FLSA rules.

Because the cost of direct care staff is the single largest cost for most all HCBS services, B&A conducts an in-depth analysis of the prevailing market wages, staff turnover rates and related costs to this cost category. We often conduct geographic analyses to evaluate the relative differences in service usage (the percent of enrolled members accessing a service and the average amount of services received among users), wage differentials, and the average driving distance travelled between beneficiaries and the providers they seek.

The administration of the provider survey typically includes piloting it with a select number of providers and offering a webinar tutorial on how to complete the survey. Upon receipt of survey responses, data is often summarized in a report with an accompanying databook where information is tabulated at the service level, regional level, or service/regional level. Baseline utilization data is often joined with the survey data results to obtain a holistic view of the impact of rate changes.

An example of a rate study report with accompanying databook completed for New Mexico has been included as Appendix C with our response. This report has been included as a way to illustrate the various ways that B&A has synthesized and presented data in a report. Please note that specific excerpts from this report, as well as others, are also provided in Appendix A for efficiency. These are cited on page 9 of our Methodology and Approach section.

Four of the five team members proposed for this engagement have worked on HCBS rate setting projects.

Introduction to the Project Team

The complete resumes for all staff appear in Appendix D.

Mark Podrazik, Project Manager

Mark Podrazik, B&A's President, will serve as the Project Manager for this engagement. In this capacity, he will serve as the primary contact to AHCCCS and will be the primary author of the final report. He will also serve as the lead for all meetings with MCOs and fully participate in the analytic plan designed for this project.

Mark has served as the Project Manager and lead author of the annual EQR report for B&A's engagement with Indiana's OMPP since 2007. He was also the Project Manager for B&A's Access to Care project with Ohio's Medicaid program. Mark has also written independent evaluations submitted either to legislators or to CMS for the States of Minnesota, New York, Oklahoma and Vermont.

Mark's affiliation with AHCCCS goes back to 1997 (while at a previous consulting firm). From 1997-2005, he was a team member or Project Manager for engagements with AHCCCS that included the rebase of inpatient rates (1997-98), calculation of DSH payments (2000 and 2001), rebase of nursing facility rates (2000 and 2001), rebase of outpatient hospital rates (2005) and evaluation of AHCCCS's reinsurance program (1999).

Steven Abele, Senior Analyst

Steven Abele, B&A Senior Consultant, will serve as a Senior Analyst on this engagement. Steve will assist in designing the analytic plan for the project. He will also lead the provider survey effort and participate with Mark Podrazik in meetings with the MCOs.

Steve has worked on all of B&A's engagements with Arizona's DDD since B&A's inception in 2006 (and, while at another consulting firm, from 2003-2006). He brings an in-depth knowledge of the services offered by DDD, its provider base, utilization patterns and areas where access has been of concern. Steve is also the principal evaluator in the development of the Rate Certification Letter submitted by DDD to AHCCCS each year.

In addition to his work with DDD, Steve has worked on HCBS rate setting projects with Arizona's Department of Health Services, Division of Behavioral Health Services and with six other states.

Ryan Sandhaus, SAS Programmer

Ryan Sandhaus joined B&A in 2016 but has used SAS for conducting analytical work for the past 11 years. Ryan will be responsible for the intake, validation and analysis of the files delivered by AHCCCS to B&A related to encounters, enrollment and providers. Since joining B&A, he has served as the lead programmer on B&A's projects for Indiana and Ohio related to access to care. He has also worked with the States of Connecticut, Maine and Vermont on hospital rate studies. Ryan will leverage the SAS programs already developed for B&A's other access to care projects and modify for use in this project in order to hit the ground running during this condensed project timeline.

Tina Brezenski, Research Associate

Tina Brezenski, a Consultant at B&A, has more than 17 years of experience in financial analysis and budgeting across multiple sectors including health care and nonprofits. Since joining B&A in 2014, Tina's area of focus has been working on B&A's HCBS rate setting projects. To date, she has conducted utilization and financial modeling on projects in seven states. She has also become adept on the use of geomapping software which she has used as a means to display results on all of these projects as well as B&A's Indiana EQR engagement.

For this project, Tina will be a key contributor to developing the maps showing provider service areas for each category of service within the GSAs. She will also utilize her expertise in using Google Distance Matrix and BING web services to compute average driving distances for members to each service provider.

Barry Smith, Research Associate

Barry Smith, a Consultant at B&A, joined the firm in 2007 and has provided a wide range of analytical support to B&A's engagements. More recently, his focus has been on administering, intaking and validating data received from provider surveys for B&A's HCBS rate setting projects. He also serves as an analyst on B&A's annual EQR for Indiana Medicaid. In 2016, Barry was a key contributor to both the Indiana EQR and Ohio Medicaid access to care studies. This included developing tables for databooks, computing average distances travelled and creating the maps to display findings.

For this project, Barry will perform similar tasks. He will manage the database for the release and intake of all provider surveys received and will analyze survey results. He will work with Ryan Sandhaus on the development of table shells for the planned databook to accompany the final report to AHCCCS.

METHODOLOGY AND APPROACH

Burns & Associates (B&A) proposes to utilize AHCCCS member enrollment, provider enrollment and encounter utilization from Calendar Year (CY) 2016 to build a baseline of service utilization for each of the 11 services requested in the Task Order: nursing facility, attendant care, personal care, homemaker, respite, habilitation, assisted living, DDD group homes, day treatment and training, adult day health, and center-based and group supportive employment programs. From the responses to bidders' questions, it appears that these services are easily segmented by provider type within AHCCCS's data warehouse. B&A proposes 12 baseline categories by splitting respite separately between the EPD and DD populations.

This analysis will serve multiple purposes in the project:

- The reporting of members (users), providers and location where services are being delivered will provide the baseline for future comparison as well as show where potential access may already be compromised;
- By analyzing CY 2016 volume for the delivery of each service, it will inform who are the highest-volume providers by locality for use in the survey stratification; and
- The baseline data, when joined with provider survey responses that will be attached to a specific service/location, can help inform predictions of future access challenges.

In addition to the primary data collection and analysis completed by B&A, we will also analyze and incorporate secondary data that has already been produced. This includes reports collected by AHCCCS or generated by the MCOs, contract requirements, and the DDD Rate Reimbursement Study (which was produced by our firm).

A detailed work plan is presented on the next two pages. There are 11 tasks identified and numerous sub-tasks. On the pages that follow the work plan, B&A identifies key aspects of each task that will build up to delivering the final report to AHCCCS. The 11 tasks with the intended completion date for each task appear below:

	Description of Task	Target Completion
1	Data request to AHCCCS	10/11/17
2	Data request to ALTCS MCOs	10/12/17
3	Analyze and synthesize non-encounter data from AHCCCS	10/20/17
4	Analyze and synthesize enrollment, provider and encounter data from AHCCCS	11/22/17
5	Analyze and synthesize data from ALTCS MCOs	10/27/17
6	Identify providers for survey release by service category	11/10/17
7	Develop draft survey and pilot with providers	11/3/17
8	Release survey and compile results	11/22/17
9	Facilitate focus group discussions with ALTCS MCOs	12/6/17
10	Cross-tab feedback from providers and MCOs with baseline access reports	12/13/17
11	Write report and prepare associated databook	1/2/18

Throughout the course of the engagement, B&A will keep AHCCCS project leads apprised of our ongoing work. In addition to planned or ad hoc conference calls, B&A has scheduled nine in-person meetings. Four meetings will be held with B&A and the AHCCCS team. Five meetings will be held with B&A and the MCOs, of which, four will be 1-on-1 meetings with each ALTCS MCO (Bridgeway, Mercy Care, United, DES/DDD) and one meeting will be with all ALTCS MCOs.

Task Number	Task Name	Responsibility	October				November				December			
			9	16	23	30	6	13	20	27	4	11	18	25
				Meeting w/AHCCCS						Meeting w/MCOs				
1	**Data Request to AHCCCS**		x											
1.1	Call with AHCCCS, prepare request for enrollment information covering CY 2016	Podrazik	x											
1.2	Call with AHCCCS, prepare request for encounters dates of service from CY 2016, Jan-Jun 2017	Podrazik	x											
1.3	Call with AHCCCS, prepare request for master provider file	Podrazik	x											
1.4	Request AHCCCS policies regarding network standards, including ALTCS EPD and DDD contracts	Podrazik	x											
1.5	Request Non Provision of Service Report information from CY 2016 to present	Podrazik	x											
1.6	Request reports submitted by ALTCS MCOs regarding network adequacy, providers reducing services	Podrazik	x											
1.7	Annual Title XIX Rate Reimbursment Study conducted by DDD (*B&A already has in house)	Abele	x											
2	**Data Request to ALTCS MCOs**													
2.1	Request policies and procedures related to provider contracting	Podrazik	x											
2.2	Request Network Management and Development Plan	Podrazik	x											
2.3	Request internal reports, Geoaccess maps	Podrazik	x											
2.4	Request provider rosters for provider types in the study with emails, phone numbers	Podrazik	x											
3	**Analyze and synthesize non-encounter data from AHCCCS**													
3.1	Compile AHCCCS network standards information for each provider category	Podrazik, Abele		x										
3.2	Identify key points of the Non Provision of Service Report for use in this project	Podrazik, Abele		x										
3.3	Identify key trends found in network adequacy reports to AHCCCS, providers who reduced services	Abele		x										
3.4	Consider results from DDD Rate Reimbursement Study into access to service analysis	Abele		x										
4	**Analyze and synthesize enrollment, provider, encounter data from AHCCCS**													
4.1	Read in enrollment data and stratify AHCCCS members by GSA, county	Sandhaus		x	x									
4.2	Read in provider and encounter data, stratify providers based on service/MCO (using HCPCS)	Sandhaus		x	x									
4.3	Share preliminary results with AHCCCS and confirm definitions of service categories	Podrazik, Sandhaus			x									
4.4	Segment AHCCCS members who used each service category by MCO/county/service	Sandhaus				x								
4.5	Create baseline reports of unduplicated clients, providers, services, payments for CY16 by	Sandhaus, Smith				x								
4.6	Identify every member/provider 'pair' by service category	Sandhaus				x								
4.7	Prepare files with member lat/lon information	Sandhaus				x								
4.8	Run Google Distance Matrix or BING web services to assign driving distance per claim	Brezenski, Smith					x	x						
4.9	Validate and compile driving distance data for members within each service category	Brezenski, Smith						x						
4.10	Prepare baseline reports of avg distance travelled by service/county/GSA (for Maricopa, by MCO)	Brezenski, Smith							x					
4.11	Create data visualization maps to show service area by service/provider/county/GSA	Brezenski, Smith							x					
4.12	Review draft results with AHCCCS of these baseline access reports	Podrazik, Abele								M6				
5	**Analyze and synthesize data from ALTCS MCOs**													
5.1	Review each MCO's policies/procedures re: provider contracting to determine impact on this study	Podrazik, Abele			x									
5.2	Review each MCO's Network Development Plan, compare to each other and AHCCCS data	Podrazik, Abele			x									
5.3	Review other reports from MCOs (e.g. Geoaccess), compare to each other and AHCCCS reports	Podrazik, Abele			x									
5.4	Intake, validate and aggregate provider demographic files from MCO to assist in survey releast	Smith			x									
6	**Identify providers for survey release by service category**													
6.1	From results in Tasks 4.4-4.5, identify total potential count of providers to survey by service	Sandhaus				x								
6.2	Identify by name the providers in each category with minimum threshold of payments (e.g. $25,000)	Sandhaus, Smith				x								
6.3	Coordinate with AHCCCS and/or MCOs to obtain missing email/phone numbers for providers	Smith				x								
6.4	Compile tracking sheet of all providers by service with contact info	Smith					x							
6.5	Crosswalk providers that are listed in more than one provider list in Task 6.4	Smith					x							
6.6	Determine unique count of providers across all services combined based on results in Task 6.5	Smith					x							

Task Number	Task Name	Responsibility	October				November				December			
			9	16	23	30	6	13	20	27	4	11	18	25
				Meeting w/AHCCCS						Meeting w/MCOs				
7	**Develop draft survey and pilot with providers**													
7.1	Meet with select providers to discuss survey and pre-set responses vs open-ended responses	Podrazik, Abele		x										
7.2	Develop draft survey comprised of questions for all providers	Abele, Podrazik		x										
7.3	As necessary, develop questions that are specific to certain service categories	Podrazik		x										
7.4	Review draft survey(s) with AHCCCS for feedback	Podrazik, Abele			M1									
7.5	Revise survey(s) based on AHCCCS feedback	Abele			x									
7.6	Contact two providers within each service category by phone to pilot survey via phone	Abele, Smith				x								
7.7	Revise surveys based on provider feedback in pilot	Abele				x								
7.8	Create survey tool in Survey Monkey	Smith				x								
7.9	Build email blasts by service category for all providers targeted to complete survey	Smith					x							
8	**Release survey and compile results**													
8.1	Release survey(s) in the field	Smith					x	x	x					
8.2	Record and post online a webinar to explain and walk through the survey	Abele					x							
8.3	Track returned emails and attempt to obtain revised email addresses by calling providers	Smith					x							
8.4	Maintain daily tracking report of surveys completed by service category	Smith					x	x	x					
8.5	Respond to requests for technical assistance from providers as necessary	Abele					x							
8.6	Read in results of survey responses, validate completion of questions answered	Smith						x	x	x				
8.7	Review any qualitative responses and develop means to organize feedback into themes	Abele								x				
8.8	Build analytic shells/pie charts to present results of survey for each survey question	Abele, Smith							x					
8.9	Review preliminary survey results with AHCCCS	Podrazik, Abele								M6				
9	**Facilitate focus group discussions with ALTCS MCOs**													
9.1	Compile MCO-specific questions for 1-on-1 meetings with each MCO to discuss desk materials	Podrazik, Abele					x							
9.2	Conduct 1-on-1 mtgs with each MCO to discuss Network Develop Plan, reports, P&Ps	Podrazik, Abele						M2-5						
9.3	Conduct follow-up with individual MCOs, as needed, based on 1-on-1 meetings	Abele							x					
9.4	Conf call with AHCCCS to summarize content/feedback from 1-on-1 meetings	Podrazik, Abele					x							
9.5	Prepare talking points/baseline data for joint MCO focus group discussion, review w/AHCCCS	Podrazik, Abele								M6				
9.6	Facilitate an in-person focus group discussion with MCO reps re: network adequacy, challenges	Podrazik, Abele									M7			
10	**Cross-tab feedback from providers and MCOs with baseline access results**													
10.1	Intake provider survey responses flagging those that have terminated or reduced services	Smith								x				
10.2	Crosswalk providers in Task 10.1 to service category, geographic region, and MCO contract(s)	Smith								x				
10.3	Intake MCO responses from focus group discussion regarding challenges in contracting	Abele									x			
10.4	Crosswalk services/regions in Task 10.3 where MCOs state contracting challenges are greatest	Abele									x			
10.5	Summarize results from Tasks 10.2, 10.4 and propose approach to AHCCCS for use in report	Podrazik, Abele									M8			
10.6	Based on AHCCCS feedback, model scenarios of potential greatest impact on access against baseline	Entire B&A team										x		
10.7	Share results of comparison of baseline maps and future scenario maps with AHCCCS	Podrazik, Abele										M9		
11	**Write report and prepare associated databook**													
11.1	Construct outline of narrative report and detailed tables/maps for databook	Podrazik							x					
11.2	Review report outline and itemized reports/maps for accompanying deliverable with AHCCCS	Podrazik, Abele								M6				
11.3	Write draft report based on findings from baseline data, provider survey, MCO focus group	Podrazik, Abele									x	x		
11.4	Based on results, develop strategies for new network standards and evaluating workforce	Podrazik, Abele										x		
11.5	Walk through draft report and accompanying databook with AHCCCS	Podrazik, Abele										M9		
11.6	AHCCCS reviews draft report and provides feedback	AHCCCS											x	
11.7	Finalize report based on AHCCCS feedback	Podrazik, Abele												x
11.8	Finalize and deliver databook containing utilization and avg distance tables/maps	Entire B&A team												x
11.9	Finalize and deliver database containing all provider survey responses	Smith, Abele												x

Tasks 1 and 2: Data Requests to AHCCCS and ALTCS MCOs

Immediately upon notice of award, B&A will begin to develop the data request for both AHCCCS and the ALTCS MCOs. For AHCCCS, B&A will request a data dictionary of the enrollment, provider and encounter tables in AHCCCS's data warehouse. From this, we will develop a draft data request of the variables requested. No later than October 10, we would like to schedule a conference call with the appropriate AHCCCS staff to ask questions in order to refine our draft data request. We will submit the final data request on October 11 in the hopes that we can receive the data requested back by October 18.

In addition to data from AHCCCS's data warehouse, we will use the conference call to learn more about secondary data that we anticipate requesting as well as data that may only be available from the ALTCS MCOs. This will enable us to prepare a more formal request of secondary data to AHCCCS (on October 11) and to the ALTCS MCOs (on October 12). We will request a one-week turnaround for this information as well.

Tasks 3 and 5: Analyze and Synthesize Non-Encounter Data from AHCCCS and ALTCS MCOs

B&A's Project Manager, Mark Podrazik, and Senior Analyst, Steven Abele, will serve as point on the analysis of non-encounter data from AHCCCS and the ALTCS MCOs, including policies and procedures regarding network standards, MCO Network Management and Development Plans, AHCCCS or MCO-generated Geoaccess reports, any Non Provision of Service Report information and the Title XIX Rate Reimbursement Study conducted by DDD. Mark Podrazik will leverage his experience as Project Manager serving as the External Quality Review Organization (EQRO) for Indiana Medicaid and the in-depth network adequacy focus study he conducted in the 2016 EQRO to efficiently review these materials. Steven Abele is the author of the DDD Reimbursement Study so he can quickly identify the potential access concerns by locality for DD-related services.

Task 4: Analyze and Synthesize Enrollment, Provider and Encounter Data from AHCCCS

The team proposed for this task completed a project similar in scope in 2016 for the Ohio Department of Medicaid (ODM) in which B&A served as the technical analysts for Access to Care report required by CMS for Medicaid fee-for-service programs. This same team also worked on the 2016 Indiana EQR study. As a result, the foundation for analytical processes has already been built by B&A and we will determine how this prior work can be leveraged and then customized for this engagement.

In summary, B&A initially segments the membership into the demographic cohorts required for the project. In this case, we will segment by the member's home county (which can then be mapped to a GSA). For some projects, we have further refined by zip code or census tract which may be helpful for Maricopa County. Then, in consultation with our client, we determine the universe of services (usually by CPT/HCPCS) and providers (usually by provider type and/or specialty). In some cases, there needs to be additional customization for select services which we will discuss with the client.

Defining the members, providers and services is done by writing a SAS program specific to each project. Ryan Sandhaus is B&A's SAS programmer assigned to this engagement. He also completed the work on B&A's Ohio and Indiana engagements.

After an initial discussion with AHCCCS to set the parameters for the study, B&A will then share with AHCCCS our preliminary findings that tabulate unduplicated clients, unique providers used, count of services received and payments for the services. These reports will be standardized in the same format for each service category. Data will be segmented for the state overall, by GSA and by county within

each service. In consultation with AHCCCS, if the data does not match other benchmark data that AHCCCS may have, we will conduct drilldown analyses and refine our queries as necessary.

With the baseline data established, B&A then identifies unique member-to-provider pairings for a particular service. Using the latitude and longitude for the member's home from the enrollment file, we determine the driving distance (not crow flies) to the servicing provider. B&A uses unique pairings to control for different billing patterns across services. For example, for a DD day program, the member may attend the day program 5 days per week. If the provider bills daily for services, there may be 250 different encounters of the member-provider combination. B&A will only count one of these in our distance study.

B&A utilizes Google Distance Matrix or BING web services to submit batches of latitude/longitude combinations to obtain the driving distance information. We can usually submit tens of thousands of these combinations in a single batch and this runs overnight. At times, a distance cannot be obtained or the result is unreliable (e.g. the latitude/longitude data suggested a driving distance of 600 miles). B&A reviews all results from the web service and excludes outlier distances out when computing average distances travelled for a specific service (e.g., < 1 mile and > 100 miles). Both Tina Brezenski and Barry Smith, who are the B&A team members proposed to conduct this work, have performed this task on numerous B&A projects and have become very adept at using the Google Distance Matrix and BING web services. Once the distances are computed for all member-provider pairings, the average distance travelled can be computed by service category and by county or GSA.

It should be noted that the driving distance metric works for most services, but not all. B&A will discuss with AHCCCS the utility of running the analytics for this metric on respite, for example, where the provider often travels to the member's home and the provider address on record is the agency, not the individual staff person performing respite.

In addition to computing the distances, B&A will utilize the coordinates of each provider within a service category in order to plot provider locations. B&A will create "heat maps" that visually show service coverage areas within a county or GSA for each service. For example, a provider will be plotted on a county map and a circle showing a five-mile radius can be drawn then a second circle can display a ten-mile radius. These maps quickly identify where access is the greatest issue (that is, areas of a county that have no concentric circles).

Separate from plotting the provider service coverage areas, B&A has also used color-coding to identify zip codes, census tracts or counties where members have lower- or higher-than-average driving distances to access the service being reviewed. Whereas the provider service coverage maps show "accessibility" (the providers that members could potentially use), the average distance maps show "availability" (the providers that members actually used). B&A has seen in other projects similar to this that accessibility is never an issue (there are plenty of contracted providers on record). This issue pertains more to availability (not all potentially accessible providers will serve any new members, so there is not real accessibility).

B&A uses the data points plotted for both accessibility and availability (the actual providers used) to inform any assessment of potential access issues. B&A will share the draft accessibility and availability maps with AHCCCS. This is scheduled for the week of November 27.

Task 6: Identify Providers for Survey Release by Service Category

The data analyzed in Task 4 will inform the number of providers that members actually used for each of the 12 service categories (recall that B&A is proposing to split Respite between EPD and DD). B&A will be tracking payments made to each provider for CY 2016 services. The unique count of providers by service category will be compared to the counts of providers that AHCCCS released in response to Bidder Question #32 of this Task Order. Rather than completing a stratified sample of providers to survey, B&A is recommending that all providers within a specific service category be considered to survey provided that they meet a certain payment threshold (e.g. the provider was paid at least $25,000 in CY 2016 for the specific service rendered).

B&A anticipates that if a payment threshold is considered, then this means that almost 100 percent of some service category providers will be surveyed (such as nursing facility, DD group home, day treatment and training) while a subset is more likely for other service categories (such as attendant care and assisted living). B&A will work with AHCCCS to determine the most appropriate threshold to consider and whether any payment threshold should be applied at the CPT/HCPCS level or at the provider type level.

Once the universe of providers to be surveyed is defined, B&A will coordinate with AHCCCS or the MCOs to try to obtain missing email addresses or phone numbers. B&A intends to build a web-based survey so email addresses will be essential. The phone numbers are intended to call individual providers to obtain an email address, if necessary.

There will inevitably be providers who cross multiple HCBS services, particularly within the domain of DD services. Likewise, some providers will cut across multiple counties or GSAs. B&A will identify not only the unique number of providers to survey by service category but also the number of unique providers across all service categories.

Task 7: Develop Draft Survey and Pilot with Providers

Shortly after project initiation, B&A will start developing a survey tool. We are proposing a web-based survey that has more pre-set responses (i.e. check the box) than open-ended questions. This is an effort to make the survey as easy and quick to complete as possible and also due to the limited project timeline. Because most, if not all, answers will have pre-set responses, B&A will meet with select providers before sharing a draft with AHCCCS to obtain feedback on the variety of pre-set answers (and the terminology) to use for each question. Given our considerable work conducting provider surveys for DDD that have all considered wages and benefits in these tools, we believe we can work with providers to obtain a representation of the types of answers we would need to include for each question.

B&A anticipates that the survey will be 10-12 questions and should take no more than five to seven minutes to complete. B&A will factor in all of the items requested in Task Order Section 4.1. Specifically, we also anticipate asking the following in some manner:

- Starting and average wage prior to January 1, 2017 and today
- Turnover and vacancy rates in CY 2016 and year to date in CY 2017
- Wages as a percent of total business costs and benefits as a percentage of total business costs in CY 2016, then same information budgeted for CY 2017 or actual year to date in CY 2017
- Recruitment or hiring challenges (e.g., decrease in applicants, applicants cannot meet minimum qualifications or background check, irregular hours/cancelled shifts)
- Recruitment strategies taken, e.g., signing bonus, retention bonus, shift differentials, new benefits