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| --- | --- |
| **CONTRACTOR:** |  |
| **LINES OF BUSINESS (LOB):** |  |

 As indicated in the table, the Contractor shall complete column ‘C’ and may complete column ‘D’ if applicable.

|  |  | **CONTRACTOR** | **FOR AHCCCS USE ONLY** |
| --- | --- | --- | --- |
| **(a)****NETWORK DEVELOPMENT AND MANAGEMENT PLAN (NDMP); PERIODIC NETWORK REPORTING REQUIREMENTS**The submission includes all of the following: | **(B)****REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW** | **(C)** **FOUND****ON PAGE:** | **(D)** **CONTRACTOR COMMENTS** | **(E)** **CODE** | **(F)** **ADDR (Y/N)** | **(G)****AHCCCS COMMENTS** |
| **ACC** | **CHP** | **ALTCS E/PD** | **DDD** | **ACC-RBHA** |  |
| 1. Attachment A – Network Attestation Statement.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. Attachment F - The Centers of Excellence Report and Checklist.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1, 7, 14 |  |  |
| 1. Description of network management, including details regarding:
2. How members access the system, and
3. Relationships between various network partners (focus on provider to provider contact and facilitation of such by the Contractor; e.g. Primary Care Physician (PCP), Specialists, Hospitals).
 | **X** | **X** | **X** | **X** | **X** |  |  | 4 |  |  |
| 1. That covered services are as accessible to AHCCCS members in terms of timeliness, amount, duration, and scope as those services are to non-AHCCCS persons within the same service area.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. That covered services are provided promptly and are reasonably accessible in terms of location and hours of operation.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. That there are sufficient personnel for the provision of all covered services, including emergency care on a 24 hours a day, seven days a week basis.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,4 |  |  |
| 1. The Contractor’s strategy for incorporating medical homes into its network and its progress in maximizing the capacity of medical homes.
 | **X** | **X** | **X** |  | **X** |  |  | 4 |  |  |
| 1. A description of the Contractor’s incentive plans to recruit and retain locally based Behavioral Health Professionals (BHPs) and Behavioral Health Medical Professionals.
 | **X** | **X** | **X** | **X** | **X** |  |  | 5, 8 |  |  |
| 1. Description of how the Contractor assesses the medical and social needs of new members to determine how the Contractor may assist the member in navigating the network more efficiently.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. A description of the Contractor’s process for allowing members PCP choice and obtaining services from other providers under the circumstances specified in 42 CFR 438.52, (b)(2)(ii).
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,4 |  |  |
| 1. Description of how members may be assigned to specialists for their primary care needs.
 | **X** | **X** | **X** | **X** | **X** |  |  | 4 |  |  |
| 1. A process for evaluating anticipated membership growth and expected service utilization given the characteristics of the population and member’s healthcare needs.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. Identify any network implications found in Contractor’s Cultural Competency or Workforce Development Plans. Identify any network development steps taken based on these plans.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,5 |  |  |
| 1. Describe the Contractor’s process for identifying and publicizing providers that offer reasonable accommodations for members such as: physical access, accessible equipment, and culturally competent communications.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,4 |  |  |
| 1. An evaluation of the prior year’s NDMP including:
2. A list of the network development actions proposed in the prior year’s NDMP,
3. Data and information that supports the outcomes, effectiveness, and/or achievements of the Contractor in implementing the previous year’s actions (inclusive of qualitative and quantitative data) and
4. An evaluation and analysis of the effectiveness of the previous year’s actions (utilizing qualitative and quantitative data) towards meeting the prior year’s NDMP identified goals.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,3 |  |  |
| 1. An overview of network issues experienced over the past year, including:
2. A description of the identified issue(s),
3. Interventions and activities implemented to resolve the issue(s),
4. Barriers identified in implementing interventions and activities, and
5. An evaluation of the effectiveness of the interventions implemented to address the issue(s) experienced.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,3 |  |  |
| 1. The Contractor’s network development actions for the current year based upon its review of the prior year’s NDMP, current identified gaps, and any network development steps identified in the current NDMP.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. Summary and analysis of the Contractor’s performance under applicable network deliverables. Where applicable, report noncompliances. This includes:
	1. ACOM Policy 417 (including the year over year analysis as specified in this Policy),
	2. ACOM Policy 436 (using AHCCCS-validated time and distance calculations),
	3. ACOM Policy 449,
	4. AMPM Policy 310-P, Attachment A, and
	5. AMPM Policy 1021 Attachment B.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1, 4,7 |  |  |
| 1. For any network deliverables not in compliance with AHCCCS standards, identify steps to bring the Contractor into compliance.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1, 4,7 |  |  |
| 1. The methodologies used by the Contractor to identify network gaps.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. The Contractor’s assessment that it has the capacity and the appropriate range of services adequate for its assigned service area.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. The Contractor’s review of Emergency Department (ED) utilization for behavioral health services for members in DCS custody and an assessment of potential network gaps.
 |  | **X** |  | **X** |  |  |  | 4 |  |  |
| 1. A description of the Contractor’s use of electronic visit verification data in assessing network sufficiency. (Refer to AMPM Policy 540).
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,10 |  |  |
| 1. Current status of the network by service type (Hospital, Nursing Facility (NF), Home and Community Based Services (HCBS), Primary Care Obstetrics and Gynecology (OB/GYN), Specialist, Oral Health, Non Emergent Transportation, Ancillary Services, etc.) by Geographic Service Area (GSA) at all levels (Contractor should consider providing a table of contracted providers by provider type and specialty in each GSA).
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. An assessment of the sufficiency of the Contractor’s NF network.
 |  |  |  | **X** |  |  |  | 1 |  |  |
| 1. The Contractor shall address how it ensures newly contracted providers subject to HCBS regulations per section 1915 of the Social Security Act [42 CFR 438.3(o); 42 CFR 441.301(c)(4)] are compliant with these regulations prior to entering the network and providing services.
 |  |  | **X** | **X** |  |  |  | 10 |  |  |
| 1. Description of efforts taken to ensure that a priority is placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institution or Alternative HCBS Setting. Institution may include Skilled Nursing Facilities (SNF), Intermediate Care Facilities for Individuals with Intellectual Disability (ICF-IIDs), and Behavioral Health Residential Treatment Centers. Alternative HCBS Setting may include Assisted Living Facilities (ALF), Group Homes, and Adult and Child Development Homes. To that end, the development of home and community based services shall include provisions for the availability of services on a seven day a week basis, and for extended hours, as dictated by member needs.
 | **X** | **X** | **X** | **X** | **X** |  |  | 9 |  |  |
| 1. Description of the available alternatives to NF placement such as ALFs, Alternative HCBS Settings, or HCBS for members.
 | **X** | **X** |  |  | **X** |  |  | 4 |  |  |
| 1. Strategies the Contractor will take to provide members with “in-home” HCBS versus placing members in Alternative HCBS settings or NFs.
 |  |  | **X** | **X** |  |  |  | 9 |  |  |
| 1. A summary of the Contractor’s process for monitoring and evaluating member placement data to support its efforts to increase the percentage of members residing in their own homes.
 |  |  | **X** | **X** |  |  |  | 9 |  |  |
| 1. The Contractor’s process for developing and implementing a network of pre- and post- employment service providers as outlined in AMPM Policy 1240-J, and how it considers geographic diversity and member choice of service providers.
 |  |  | **X** |  |  |  |  | 10 |  |  |
| 1. Specific pro-active strategies/actions the Contractor will take to reduce the percentage of HCBS members in Alternative HCBS Settings once 20% or more of its HCBS membership resides in Alternative HCBS Settings. If any GSA served by the Contractor is currently greater than 20%, the Contractor must demonstrate the implementation of its strategies/actions.
 |  |  | **X** |  |  |  |  | 9 |  |  |
| 1. As applicable, a discussion of planned changes to the methodologies for the Appointment Availability reviews and an anticipated timeframe for submission of the proposed changes as specified in ACOM 417.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. For each county in the contracted GSA(s), (excluding Maricopa and Pima counties) report the percent of members within 50 miles of a Behavioral Health Residential Facility. If less than 90% of members are within 50 miles, discuss how the Contractor ensures access.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. Describe the process when a Residential Treatment Center (RTC) placement is medically necessary but unavailable, including how the member’s needs are addressed and interventions conducted while maintaining member safety. Include an analysis of how many members fall into this category and their average length of time in this category (in calendar days).
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,7,8 |  |  |
| 1. Integrated network for members at risk/with Autism Spectrum Disorder who do not qualify for DES/DDD services.
 | **X** | **X** | **X** |  | **X** |  |  | 4,7,8 |  |  |
| 1. A description of its network of Applied Behavioral Analysis (ABA) therapists available in each GSA, an assessment of the sufficiency of the network (to include member data of how many members have received services compared to capacity of ABA therapists), and any steps taken to address insufficiencies.
 | **X** | **X** | **X** | **X** | **X** |  |  | 4,6,7,8 |  |  |
| 1. A general description of the Contractor’s network of:
	1. Laboratory services including pathologists available for physician referral and how the Contractor assesses the sufficiency of their network,
	2. Indian Health Care Providers (IHCP) not including health care programs operated by the Indian Health Service (IHS) or a 638 tribal facility that provides services to Title XIX members, and
	3. Treat and Refer providers (provider type TR).
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. A general description of the Contractor’s network of locally-established, Arizona-based, independent Peer-Run and Family-Run Organizations.
 | **X** | **X** | **X** | **X** | **X** |  |  | 8 |  |  |
| 1. The Contractor’s analysis demonstrating it has a network that includes sufficient family planning providers to ensure timely access to covered services, including out-of-network providers per AMPM Policy 420 42 CFR 438.206(b)(7).
 | **X** | **X** | **X** | **X** | **X** |  |  | 6 |  |  |
| 1. Network availability of providers who connect members to social and economic supports.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. A general description of the Contractor’s network of community based, family support services in urban, suburban, and rural areas of the state, including behavioral health services.
 | **X** | **X** | **X** | **X** | **X** |  |  | 8 |  |  |
| 1. A general description of the Contractor’s network of innovative delivery mechanisms, including mobile providers in rural or under-served areas, field clinics and virtual clinics.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,4,8 |  |  |
| 1. A general description of the Contractor’s network of providers who offer telemedicine, teledentistry, and asynchronous technologies by GSA.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,8 |  |  |
| 1. A general description of the Contractor’s network of providers who are trained to conduct end of life conversations and advanced care planning, and how the Contractor ensures this network is adequate.
 | **X** | **X** | **X** | **X** | **X** |  |  | 4 |  |  |
| 1. A general description of integrated network design by GSA for the following populations:
2. Individuals with Special Health Care Needs (including members with a CRS designation),
3. Individuals served by Arizona Early Intervention Program (AzEIP),
4. The homeless,
5. Individuals in the justice system (adults and children), and
6. Those in border communities.
 | **X** | **X** | **X** | **X** | **X** |  |  | 4,6,8,12 |  |  |
| 1. An assessment of the sufficiency of the network by GSA, including any steps taken to address insufficiencies for the following populations (as applicable):
2. Members needing Dialectical Behavioral Therapy – Adult and Children (Separately),
3. Members receiving Peer and Family Support Services,
4. Veterans,
5. Survivors of sex trafficking,
6. Transition-Aged Youth, and
7. Members ages zero through five and addressing the number of providers that provide specific treatment modalities for this population (e.g., Circle of Security, Child-Parent dyadic therapy, Child-Parent psychotherapy, etc.).
 | **X** | **X** | **X** | **X** | **X** |  |  | 4-c, d,7,8 |  |  |
| 1. A general description of the integrated network design by GSA for the following populations (as applicable) needing:
2. Sexual offender treatment – Adult and Children (Separately), and
3. Sex Abuse Trauma – treatment supports and services - Adult and Children (Separately).
 | **X** | **X** | **X** | **X** | **X** |  |  |  7,8 |  |  |
| 1. A general description of the integrated network design by GSA for high risk populations applicable to the Contractor’s line of business with substance use disorders, including:
2. Pregnant women or women with, dependent children,
3. Persons who use drug by injection,
4. Adults and children with Opioid Use Disorder, and
5. Adolescents.
 | **X** | **X** | **X** | **X** | **X** |  |  | 4,6,7,8,12, 13 |  |  |
| 1. A general description of the integrated network design by GSA to provide services consistent with the American Society of Addiction Medicine (ASAM) guidelines for the following populations:
2. General membership requiring access to the following types of substance use disorder treatment:
	1. Medications for Opioid Use Disorder (MOUD), formerly known as Medication Assisted Treatment (MAT),
	2. Outpatient,
	3. Intensive Outpatient,
	4. Partial Hospitalization, and
	5. Residential Inpatient.
 | **X** | **X** | **X** | **X** | **X** |  |  |  7,8 |  |  |
| 1. A general description of the integrated network design by GSA for the following populations (as applicable):
2. Members requiring marriage and family therapy,
3. Members with trauma-related disorders,
4. Members requiring Gender Identity and Sexual Orientation supports and services,
5. Members undergoing court-ordered treatment, and
6. Members transitioning from a crisis event and requiring additional services.
 | **X** | **X** | **X** | **X** | **X** |  |  |  6,7,8 |  |  |
| 1. A general description of the Contractor’s network of providers and facilities that meet the needs outlined in A.R.S. Title 36, Chapter 18, Article 2, under ‘Local Alcoholism Reception Centers’’.
 | **X** |  |  |  | **X** |  |  | 7,8 |  |  |
| 1. A general description of how the network is designed for special populations. At a minimum these populations include:
	1. Non-Title XIX/XXI eligible Serious Mental Illness (SMI) members.
 |  |  |  |  | **X** |  |  | 2,7,8,13 |  |  |
| 1. A general description of how the behavioral health network is designed for special populations. At a minimum these populations include members in DCS custody that are:
2. Aged 0-5 requiring evidence-based practices and specialty services,
3. Seeking respite services, and
4. Receiving Therapeutic Foster Care Services.
 |  | **X** |  | **X** |  |  |  | 2,7,8 |  |  |
| 1. An general description of the current network of qualified professionals who can assess and treat children who have experienced trauma in varied ways; and provide other specialized services needed by children currently in foster care.

Address any workforce or network development steps necessary to develop a network of qualified professionals. |  | **X** |  | **X** |  |  |   | 7 |  |  |
| 1. A general description of how the network is designed for special populations, including at a minimum, children with complex needs including those formerly in foster care.
 | **X** | **X** | **X** | **X** |  |  |  | 7,8 |  |  |
| 1. A general description of how the network is designed for special populations, including at a minimum, individuals requiring Special Assistance.
 |  |  | **X** | **X** | **X** |  |  | 8 |  |  |
| 1. A description of the network sufficiency for integrated services to Title XIX/XXI eligible members determined SMI.
 |  |  | **X** | **X** | **X** |  |  | 1,8 |  |  |
| 1. Describe the crisis system network by:
2. Identifying the current number of contracted crisis mobile team providers, the locations of each provider, the number of available mobile teams, the number of persons on each team, staff qualifications, hours of coverage and communities served including a listing and a description of current Memorandum Of Understanding (MOU)s with crisis call centers and Tribal partners, and
3. Providing a detailed listing and description of the Contractor’s network of crisis observation/ stabilization and detox facilities by county including the number of beds available to serve children and the number available to serve adults.
 |  |  |  |  | **X** |  |  | 8,11 |  |  |
| 1. Assess the performance of the crisis system by:
2. Assessing crisis call times, reporting measures and contractual standards,
3. Reviewing the timeliness of mobile team response and outcomes by County and requestor, including, community stabilization rates, and
4. Assessing the performance of crisis observation / stabilization and detox facilities, by County including re-admissions within 30, 60 and 90 days.
 |  |  |  |  | **X** |  |  | 8,11 |  |  |
| 1. Identify any planned expansions or changes to the existing crisis system.
 |  |  |  |  | **X** |  |  | 8,11 |  |  |
| 1. Describe the process for addressing preventable crisis stabilization and psychiatric in-patient utilization. Include:
2. Analysis of the causes, and
3. A description of the strategies employed to reduce utilization for preventable crisis stabilization and psychiatric in-patient services.

Strategies should include but not be limited to:1. Physician coverage/call availability after hours and on weekends,
2. Same day behavioral health prescriber appointments,
3. Nurse call-in centers, information lines, member services,
4. Urgent Care/Crisis facilities, and
5. Expansion of support and rehabilitation services.
 | **X** | **X** | **X** | **X** | **X** |  |  | 8,11 |  |  |
| 1. Description of the interventions the Contractor implements to reduce avoidable/preventable ED utilization and the outcome of those interventions.
 | **X** | **X** | **X** | **X** | **X** |  |  | 4 |  |  |
| 1. A description of the activities the Contractor implements to address and reduce no-show rates including:
2. An evaluation and analysis of the Contractor’s no-show rates (inclusive of the current and prior year no-show rates with year to year trending),
3. Current interventions,
4. An evaluation and analysis of the efficacy of its efforts/current interventions utilizing qualitative and quantitative data, and
5. New or revised interventions the Contractor intends to implement based on the Contractor’s evaluation and analysis of its most recent no-show rate data.
 | **X** | **X** | **X** | **X** | **X** |  |  | 3 |  |  |
| 1. Description of how the Contractor addresses the loss (closure, contract termination) of a major healthcare provider (hospital, NF, large provider group).
 | **X** | **X** | **X** | **X** | **X** |  |  | 1,2 |  |  |
| 1. Immediate short-term interventions when a gap occurs, including expedited or temporary credentialing.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. For all out of network providers used in the past Contract Year Ending (CYE), provide a table that reports the following:
2. Provider Name,
3. Location,
4. Provider Type, and
5. Times used in the CYE.

Analyze the data for potential network gaps, identifying any special populations or services that are more likely to be served out of network. Discuss any network gaps and how they will be addressed. | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. Describe the sufficiency the Contractor’s out of state behavioral health placement options by:
	1. An analysis of any network gaps resulting in out of state placements, identifying any strategies for expanding in-state services to minimize or alleviate the need for out of state placements. The Contractor should consider specific programming (this refers to subclass of facility as well as specific programming such as sex offender, eating disorder, autism, etc. in addition to the facilities themselves),
	2. Identifying supportive services to manage continued in-state progress (e.g., case management, parenting classes, drug testing, peer support, etc.), and
	3. Include average length of stay in out-of-state placements and analysis of barriers/solutions to get members back to in-state.
 | **X** | **X** | **X** | **X** | **X** |  |  | 4,7,8 |  |  |
| 1. The methodology used by the Contractor to communicate when its Medical Management (MM) staff identifies a shortage of providers either by provider type or geographic area. Also address how this communication is documented.
 | **X** | **X** | **X** | **X** | **X** |  |  | 4 |  |  |
| 1. Coordination between internal departments on issues related to network sufficiency including a comprehensive listing of all committees and committee membership where this coordination occurs. Identification of members should include the department/area (e.g. Quality Management (QM), Medical Management/Utilization Management (MM/UM), Grievance (GRV), Finance (FIN), CLAIMS) that they represent on the committee.
 | **X** | **X** | **X** | **X** | **X** |  |  | 2 |  |  |
| 1. Methodology(ies) the Contractor uses to collect, analyze, and incorporate into network planning member, provider, staff, and other stakeholder feedback about the network’s design and performance. The Contractor shall address the role of member surveys, including any Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey data, and network related member complaints.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. Contractors shall address provider forums, the extent in which the Contractor has periodically met with a broad spectrum of behavioral and physical health providers to improve service delivery, and any network implications identified in the forums.
 | **X** | **X** | **X** | **X** | **X** |  |  | 1 |  |  |
| 1. Contractors shall address Member Advocacy/Member Council activities.
 | **X** | **X** |  | **X** | **X** |  |  | 1,8 |  |  |
| 1. Address network implications of member/provider council activities.
 |  |  | **X** |  |  |  |  | 1 |  |  |
| 1. The status of affordable housing networking strategies and innovative practices/initiatives.
 | **X** | **X** | **X** | **X** | **X** |  |  | 12 |  |  |
| 1. A description of the Contractor’s process for identifying providers to offer:
2. Prevention and treatment services through the Substance Abuse Block Grant (SABG), and
3. Treatment services through the Mental Health Block Grant (MHBG).

Additionally, the Contractor must identify its current network of providers for each grant. |  |  |  |  | **X** |  |  | 13 |  |  |