Ready, Set, Go! The Readiness Review Process for Care Coordination and Provider Network Adequacy in Arizona

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This case study summary is based on the opinions expressed by state officials during interviews and email exchanges between 2012 and 2013. It does not reflect AARP policy or opinion.

Overview

The Arizona Health Care Cost Containment System (AHCCCS)—the state’s Medicaid program—created the Arizona Long-Term Care System (ALTCS) as part of the state’s mandatory Medicaid managed care program. The program began serving clients in its statewide Medicaid managed long-term services and supports (LTSS) program in 1989. The state currently contracts with four managed care organizations (MCOs) and eight tribal contractors to provide managed LTSS to approximately 25,000 older adults and individuals with physical disabilities, and to approximately 25,000 individuals with developmental disabilities. ALTCS benefits include Medicaid-financed primary and acute care and LTSS (including nursing facility and home- and community-based services).

The AHCCCS administers the ALTCS program and is the sole state agency responsible for conducting readiness reviews with contracted MCOs. According to one state official: “We do it all. We have our own financial people and our own claims and encounter data folks to review those aspects for readiness.”

Arizona uses desk review of documents as its primary method to ensure MCO readiness to provide managed LTSS. According to one state official: “The vast majority of our review is a paper process that takes place at our offices. But we do go onsite to look at the MCO’s offices and to see whether the information technology [IT] systems are working properly. We do a walk-through to make sure the IT systems are operable, and we test their encounter data submissions. While we are onsite, we also take a look at any recent policies or procedures that we haven’t seen yet.”

Shortly after awarding a managed LTSS contract, the state sends the MCO a Readiness Assessment Tool (RAT) (Appendix A). The tool consists of 13 review domains, including case management. Responses in each domain are rated as follows: C = Critical; P = Pending; N = No Action; and D = Done. The MCOs are required to have a “D” rating for each requirement within the 13 domains before they are considered ready to provide services and are allowed to begin enrollment. According to one official: “With our last contract, it took [the MCOs] four and one-half months to complete the
tool.” To complete the RAT, MCOs send the AHCCCS detailed written policies, procedures, and protocols that outline how the requirements specified for each domain will be met.

**Readiness to Provide Care Coordination Services**

In Arizona, MCO readiness to provide case management is primarily determined through desk review. AHCCCS officials said they conduct a thorough desk review of relevant case management training materials to ensure case managers are receiving instructions consistent with state requirements. Relevant documents (see Appendix A) include the following:

- Case manager policies and procedures
- Case manager orientation and training plan
- Ongoing training procedures for case manager
- Case manager caseload management and accessibility (including backup systems)
- Plans for monitoring case manager performance (Appendix A)

State officials said the state places great emphasis on case management training. Although contracted MCOs are primarily responsible for ensuring case managers are well trained, the state regularly brings in consultants to provide technical assistance and training to case management administrators (CMAs)—people who supervise frontline case managers—who work for the MCOs. The CMAs are expected to communicate the state’s training information to frontline case managers. AHCCCS officials also said they provide ongoing support to the MCOs to ensure full compliance with the AHCCCS’s case management policies and procedures. According to one state official: “We have

well-established policies and procedures. The consultant establishes a regimented training and oversight process to monitor MCO performance in this area.”

State officials in Arizona said it is critical that states stay involved in care coordination training over the long term in order to ensure consistency in the approach to coordinating member care—especially when there are multiple MCOs under contract—and to ensure adherence to minimum requirements that the state has established for care coordination. Arizona officials said they accomplish this goal by directly sponsoring (and funding) quarterly training for those who supervise care coordinators. One official also said they consider this cost “part of effectively administering a quality long-term care program. Investment in training and education is critical to facilitating the provision of high-quality care coordination services.”

The state holds quarterly meetings with the CMAs to discuss case management issues that arise in the field. It also monitors documentation of case management services on an ongoing basis. To ensure case management services are being provided consistently among all the case managers, the MCOs must provide the state with written processes that the MCO will use to measure the consistency of case managers’ assessments or evaluations, referred to as inter-rater reliability.

State officials go on site to review the MCO’s offices and to see whether their IT systems can support the case management function. They note an essential linkage between well-functioning IT systems and case management. Once a care plan is developed for a member, the case manager determines what services that person requires. The services are then entered into the MCO’s IT system, which is designed to accurately send the
service order(s) to the relevant service providers in a timely manner.

**Determination of LTSS Provider Network Adequacy**

State officials agreed that it is critical to make sure that the MCOs have adequate staff members and providers in place to carry out all contract requirements. The AHCCCS uses desk review to determine provider network adequacy for its managed LTSS program. This involves a quarterly review of all providers contracted with each MCO. The MCOs also must verify adherence to the AHCCCS’s minimum network standards for acute and selected LTSS service providers. LTSS service providers subject to these standards include nursing facilities, alternative residential settings, and in-home care agencies (see Appendix B for the minimum network standards). The minimum standards set forth the number of provider or provider entities with which the MCO is required to have contracts. In addition to minimum network standards, the state sets limits on the amount of time a consumer may be required to spend and distance they may be required to travel to access LTSS providers. MCOs that are unable to meet required standards must document the reason(s).

The AHCCCS also requires that each MCO annually document its efforts to enhance network capacity and how it will address any network gaps. Additionally, the state requires MCOs to demonstrate that they have fully executed contracts with all relevant managed LTSS providers before they are allowed to serve clients. If an MCO has difficulty meeting the established network adequacy standards, state officials may occasionally assist by working with a provider and the MCO to finalize a needed contract. According to one state official: “The MCO may run into difficulty finding a certain type of LTSS provider in a certain area. The state would reach out to this provider type on the MCO’s behalf and help with the negotiations to get the provider to contract with the MCO.”

State officials go on site to see that the MCO’s IT system can accurately pay provider claims. One way to observe this is to run “dummy” provider claims through the MCO’s IT system and observe whether the system is able to accurately process the claim. During a review of the IT system, state officials want to ensure the system is able to pay the right provider at the correct rate.

**Advice from State Officials**

State officials stressed the importance of having comprehensive and standardized processes to determine MCO readiness before awarding the managed LTSS contract. They noted that having things in place before the contracts are executed allows a state to “hit the ground running” during the readiness review process. State officials also said that it is important to partner with MCOs to help them meet state requirements. Officials agreed that the MCO’s success makes the state agency’s job easier.

State officials cautioned states new to managed LTSS to keep in mind that the phrase “readiness review” is really a misnomer; states have to stay very closely involved during the MCO’s first year of operation to conduct ongoing assessments and to provide technical assistance when necessary. Finally, state officials said the review process is “extremely labor intensive” and can take months to complete. Thus, states need to take this into consideration when planning a launch date to begin transitioning older adults and people with disabilities from fee-for-service into managed care.
Endnotes

1 Encounter data are records of the health care services for which MCOs pay and—in many states—the amounts MCOs pay to providers of those services. Encounter data are conceptually equivalent to the paid claims records that state Medicaid agencies create when they pay providers on a fee-for-service (FFS) basis. States that contract with MCOs to deliver Medicaid services typically require those MCOs to report encounter data to the state so that the state has a full record of all the services for which the state is paying, either directly through the FFS system or indirectly through MCOs. J. Verdier and V. L. H. Byrd, Collecting, Using, and Reporting Medicaid Encounter Data: A Primer for States (Washington, DC: Mathematica Policy Research, October 19, 2011).

2 During desk review, state agency staff review detailed documents submitted to the agency by the MCO that outlines certain processes. For example, the MCO might submit a detailed description of how it will train individuals who manage care coordinators. State agency staff review these documents to ensure they are comprehensive and describe a process that supports agency goals.

3 During onsite review, state officials go to the MCO’s offices to observe particular processes. Officials may, for example, go on site to see for themselves whether the MCO’s IT systems are functioning adequately, or to conduct interviews with care coordinators. They may also inspect the premises to ensure the MCO is prepared to conduct business in accordance with contract requirements.

4 Note that the revised RAT in Appendix A was only used when Arizona awarded contracts for incumbent MCOs. Because no new MCOs were added during the 2012 procurement process, the RAT is not as comprehensive as it would be if new MCOs were being added.

5 The 13 domains are administration and management; behavioral health; case management (or care coordination); delivery system; medical management; quality management; member services; claims processing; encounter reporting; financial reporting (including initial capitalization, performance bond requirements, and subcontracting requirements); grievance system; physical plant; and management information systems.

6 Arizona refers to care coordinators as case managers.