MANAGED CARE READINESS

A SELF-ASSESSMENT TOOL FOR HIV SUPPORT SERVICE AGENCIES

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH RESOURCES & SERVICES ADMINISTRATION
HIV/AIDS BUREAU

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THE SELF ASSESSMENT MODULE SERIES

This self-guided tool is one in a series developed for Ryan White CARE Act grantees and planning bodies to help them assess their effectiveness in critical areas of responsibility as they plan and deliver HIV/AIDS services. Each covers a separate topic, such as needs assessment, comprehensive planning, and priority setting and resource allocation. Modules may be used independently or as a series.

The module design is to facilitate self-assessment. Use is completely voluntary. Grantees and planning bodies are free to determine which area(s) to assess, when to do so, how extensive to make the effort, and with whom results will be shared.

HAB project officers and technical assistance staff are available to introduce the modules or respond to concerns raised during the self-assessment process. Contact your project officer if you have any questions.

MANAGED CARE AND HIV/AIDS SUPPORT SERVICE AGENCIES

Managed care merges health care financing and delivery in a system where the payer exercises some control over provider selection, treatment options, coverage, and payment methods. The impact of managed care on financing and care of HIV-infected individuals is growing. Under Medicaid, the largest payer of HIV care, the number of HIV-infected individuals enrolled in Medicaid managed care has increased significantly. State legislatures are making significant changes to Medicaid and other health insurance programs in an effort to reduce costs and expand access to care. States are shifting large segments of their Medicaid enrollees from a retrospective fee-for-service payment system into a prospectively funded managed care system. (However, some States have discontinued managed care in their Medicaid programs, reflecting the complexity of public approaches to financing of care.)

Other payers are also experiencing increased managed care enrollment among their beneficiaries. In some health care markets, persons with HIV have enrolled in significant numbers in Medicare's managed care program, Medicare+Choice. This often provides access to pharmaceutical coverage and reduced cost sharing for ambulatory care. In the private health insurance market, HIV-infected individuals receiving health insurance coverage through their employers are often enrolled in some form of managed care.

These changes affect both HIV-infected individuals and their care providers. HIV support service agencies can help make transitions easier by assisting managed care plans and payers, such as Medicaid, with the design of HIV care systems. They can help shape the financing of high quality HIV services, ensure their agency's long-term solvency, and enhance access to care for HIV-infected populations. Specific roles for HIV support service agencies in a managed care environment might include:

- Offering services covered by managed care plans that are purchased under contract with community-based organizations.
- Establishing linkage agreements so that they can offer support services through referrals.
- Educating managed care plans about the unique needs of PLWH enrolled in managed care.

PURPOSE OF THE MODULE: PLANNING FOR MANAGED CARE PARTICIPATION

Many support service agencies do not have a formal collaborative relationship with a managed care plan but wish to assess their managed care readiness (e.g., determining what they need to do to participate, defining unique qualities they may offer such as enhancing contract or linkage agreement negotiations and network development processes). Other providers who are part of a plan are looking to make changes in order to improve utilization, costs, client satisfaction, and quality of services.

This module is designed to an array of HIV support service agencies participate in managed care networks. It walks users through a rapid assessment of their managed care readiness in such roles as contractors, informal partners through linkage agreements, or advocates for their clients. The document also calls for development of action plans that can be used to provide contracted services (or do a better job if already involved) and/or to fulfill critical advocacy and monitoring functions on behalf of clients. The module:

- ☑ Provides an easy method for an agency's staff and Board of Directors to assess their managed care readiness—without requiring technical expertise in managed care concepts.
- ☑ Identifies an agency's specific strengths and weaknesses as they relate to managed care readiness.
- ☑ Determines the benefits and pitfalls related to partnering with plans.
- ☑ Helps develop a focused action plan that lays out other activities that must be undertaken such as strategic planning, organizational development, staff training and technical assistance (TA), and resource identification.

☑ Is a first step in an agency's managed care strategic planning process. This plan should include: agency short and long-range goals and objectives for managed care participation; analysis of whether the mission of managed care plans diverge or complement the agency's mission; identification of changes that must be made in the agency's mission or operational or business plan; a set of operating principles to guide managed care participation, such as financial risk bearing, access standards, and utilization management; a work plan with tasks, time frames, milestones, and the name of staff responsible for accomplishing the tasks; identification of TA and other resources that will be needed to undertake the strategic planning process; potential collaboration with clinical providers and networks that can market and negotiate contracts with managed care plans; and a process for gaining the input of agency clients.

☑ Provides an opportunity for collaborating support service agencies to pool the results of their managed care readiness assessments as part of efforts to develop an integrated service delivery system.

How To Use The Module

This self-assessment module will provide a "snap-shot" of your agency's current strengths and weaknesses in activities related to participation in managed care. In completing this tool, your agency will identify areas requiring further development and design a plan of action to carry out the desired changes. Since the results of the tool are based on your agency's current circumstances, you should consider repeating the exercise periodically as things change and you participate in managed care system development. In this way, you can regularly assess progress in areas where weaknesses were previously recognized and identify new areas requiring attention.

Who Should Use This Module?

The module is designed for support service agencies engaged in activities to improve health outcomes by providing services that prevent unnecessary health care expenses; reduce economic, social, or other barriers to access to health care; and eliminate psychosocial crises. Support services agencies offer a wide array of services, including but not limited to case management, mental health, substance abuse treatment, nutrition, health education, other ancillary health services, patient education and adherence support services, secondary prevention services, outreach to HIV-infected individuals, and transportation.

The module asks the team to assess your "agency." In some cases, the agency is a single organizational unit for which HIV services are the single focus. In other cases, HIV programs completing this guide are located in larger multi-program organizations. If your HIV program is in such an organization, assess the policies, resources, and staff of your organization as they directly affect the HIV program. In organizations with multiple HIV program sites, it is possible that some but not all sites are involved in managed care activities. In such cases, separate assessments of each site should be conducted. The results of the self-assessments of the various sites can be compared to identify areas in which readiness varies from site to site.

Activities in the Self-Assessment

Major activities required to complete this module are outlined below, with suggestions provided on how to complete each.

☑ **Form a Workgroup**. Ideally, your agency's managed care strategic planning team should complete the module. A group of 5-10 is suggested. A chairperson should be appointed. Sections of the module should be completed by team members with the greatest level of expertise in that area. In completing sections, team members should discuss the statements posed and score the statements based on consensus. Senior managers responsible for agency operations, management of the HIV program, direct service staff supervision, finance, and information systems should work on teams to complete the module. The Board of Directors should participate in completing module sections focusing on Board-related activities. Board members should also be encouraged to be actively involved in completing other sections as well. They should also participate in completing the assessment summary and approving the resulting plan of action.

☑ **Review and Adapt the Module**. Review of all module sections at the outset will facilitate its implementation and minimize frustration among workgroup members. Distribute the module to all members of the workgroup approximately one week before the first workgroup meeting. The team will need to review the full guide in order to be prepared to identify information needed to complete the self-assessment and assign sections. The initial workgroup meeting should be used to clarify the purpose of the self-assessment, determine the scope of the effort, outline a process (e.g., how module questions will be answered such as documents to review and interviews to conduct prior to convening the group to discuss sections), set a timeline for completing the effort, assign tasks to members (e.g., assign sections to review), and clarify member questions.

☑ **Collect Information and Conduct Interviews**. Once the scope of the self-assessment has been determined, workgroup members should compile information to help them answer module questions. This may include collection and review of documents and interviews with key people. The scope of these activities will be determined in Step 1 above. In order to be completed in a timely manner, this will likely require the involvement of more than one person. When planning interviews, it is advisable to plan which questions in the module will be discussed with each interviewee.

☑ **Answer and Score**. Each section of the guide includes an introduction, identifies which staff should complete the section (which may vary based upon your unique staffing patterns), and poses a series of self-assessment statements. Recommended is workgroup discussion and consensus agreement on each statement and its score. Information and interviews conducted in the prior step should be used to inform the discussion, which can occur in meetings or telephone conference calls. Some questions may require significant discussion in achieving consensus. A facilitator may be needed.

Statements either call for a numeric score based on the strength of agreement or a true or false (using yes/no) response. Some statements may not be scored but rather determined to be "not applicable/skipped"; this should be reserved only for items that are truly not in the control of your agency rather than to statements that require some investigation or consensus building among team members.

In each section, numeric item scores are tallied as a summary section score, which is then divided by the number of statements that are scored. By dividing the total points by the number of scored statements, you will have a single score of from 0 to 3 for each section. Combined with a qualitative assessment of strengths and weaknesses in each section, scores can be helpful in highlighting areas where items are in place (i.e., scores of 2 and 3) and areas where changes or enhancements should be considered (scores of 0 to 1) as your agency undertakes managed care strategic planning and organizational development activities to prepare for managed care participation.

Section scores can also be placed on the master score sheet (page 47). This will help you in comparing scores across sections.

There is no ideal total readiness score. The higher your agency scores in your self-assessment, the more prepared your agency is likely to be. There is probably room for improvement in at least some of the dimensions of managed care readiness. Remember that assigning scores is not the ultimate goal of the self-assessment. More important is discussion and consensus on what is working well and what changes are needed.

☑ **Develop Action Plans**. After completing each section, create an action plan for the area covered in that section. (Note that the first section is an overall assessment and does not call for an action plan.) Pay particular attention to addressing items that were scored 0 to 1 because they may be areas for attention. However, don't lose sight of your strengths when planning future efforts.

A format is provided for developing action plans for each section, but it can be modified to meet your needs. Make sure to assign a time line and a lead person responsible for completing the action item. Once the section-specific action plans are done, develop an overall plan that prioritizes what should be done first.

How Much Time and Money are Required?

The self-assessment process has been designed to be very low cost. Time is the principal investment. Time required to complete the guide will vary between agencies based on their existing managed care expertise and the availability of information required to complete sections of the guide. The process should take from 8-12 weeks, beginning with tailoring the module to the local environment and ending with an action plan and reporting of results. A sample time line is as follows:

Phase I Getting Ready

Week 1: Convene to discuss whether to complete the self-assessment process.

Week 2: Form a workgroup.

Weeks 3-4: Review the module and adapt it.

Phase II Collect Information

Weeks 5-8: Review documents and conduct interviews.

Phase III Answer and Score

Weeks 9-10: Workgroup meets to discuss and score

Phase IV Action Plans

Weeks 10-11: Develop action plans for each section.

Week 12: Develop an action plan that prioritizes what to complete first.

SELF ASSESSMENT QUESTIONS

1. KNOWLEDGE AND CAPABILITIES IN AREAS OF INTEREST TO MANAGED CARE PLANS

Begin by assessing your HIV program's overall managed care readiness. This will help you assess your program in more detail using the following sections. Senior managers and Board members should complete Section 1. Check the box with the score that best describes your level of agreement with the statement. Then add up your scores. Items with scores less than 2 indicate areas that require particular attention.

	Strongly Disagree Or Don't Know			***Strongly Agree***
1. Our HIV program's management staff members are knowledgeable about managed care concepts.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
2. Our HIV program's management staff members understand the status of managed care approaches taken by our State's Medicaid and commercial insurance companies.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
3. We understand how our services complement and enhance delivery of HIV clinical care in a managed care environment.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
4. We can offer an array of HIV support services to managed care plans.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
5. We are willing to consider expanding our activities to meet the support service needs of HIV-infected persons enrolled in managed care.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts

	Don't Know	***No***	***Yes***
6. At least one senior level manager is designated to coordinate our managed care activities.	❑ 0 pts	❑ 0 pts	❑ 3 pts
7. A live telephone coverage system is in effect to handle client emergencies seven days a week, 24 hours a day.	❑ 0 pts	❑ 0 pts	❑ 3 pts
8. We have an effective client appointment system that meets reasonable standards for access.	❑ 0 pts	❑ 0 pts	❑ 3 pts

1. KNOWLEDGE AND CAPABILITIES IN AREAS OF INTEREST TO MANAGED CARE PLANS (CONTINUED)

	Strongly Disagree Or Don't Know			*Strongly Agree*
9. Our HIV program has a clearly defined service area.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
10. We have the capacity to meet the needs of our current client load as well as to accommodate additional clients.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
11. Our financial and accounting systems can track the costs and utilization of our services.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
12. We have client utilization, billing, and revenue data.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
13. Our staff can accurately measure the number of clients we serve; their demographic, clinical, and health insurance characteristics; and the services they receive.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
14. Our staff has the capability to analyze information and identify trends in utilization, costs, and quality indicators.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
15. We have a written quality assurance plan that assures high quality to our clients.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
16. We have a utilization management plan that includes policies and procedures for managed care activities.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
17. Our clients are satisfied with our staff and the services they receive.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts

TOTAL POINT ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3

2A. UNDERSTANDING MANAGED CARE CONCEPTS: BOARD OF DIRECTORS

Your agency's Board of Directors, management staff, and direct service providers must be knowledgeable about managed care concepts and committed to participation in managed care systems. Functioning in the managed care marketplace is likely to require an additional set of skills than are currently being used. You need to assess the capabilities and responsibilities of your Board and staff to operate in this new environment.

Involvement in managed care may require your Board to understand new concepts.

TOTAL SCORE	
DIVIDED BY NUMBER OF STATEMENTS ANSWERED	
EQUALS **SCORE**	

Maximum possible score is 3.

Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

Not At All Knowledgeable → *Very Knowledgeable*

Our Board of Directors is knowledgeable about:

	0 pts	1pt	2 pts	3 pts
1. Managed care concepts	❑	❑	❑	❑
2. Case coordination with HIV clinicians	❑	❑	❑	❑
3. HIV clinical care	❑	❑	❑	❑
4. Quality assurance/ Quality improvement	❑	❑	❑	❑
5. Medicaid policy	❑	❑	❑	❑
6. Marketing	❑	❑	❑	❑
7. Contracting with managed care plans	❑	❑	❑	❑
8. Management information systems	❑	❑	❑	❑
9. Unit cost estimation	❑	❑	❑	❑

2B. UNDERSTANDING MANAGED CARE CONCEPTS: MANAGEMENT AND DIRECT SERVICE STAFF

Your agency's management and direct service staff need to have the capability to undertake operations related to managed care. It is also important to have staff designated to coordinate managed care activities. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores. In addition, list staff members with the capability in and/or responsibility for each of the areas listed.

	Not At All Knowledgeable → *Very Knowledgeable*				*Staff Responsible For Function*
Our management and direct service staff are knowledgeable about:					
1. Managed care concepts	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	
2. Marketing to managed care plans	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	
3. Managed care contract negotiations	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	
4. Managed care coordination/liaison	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	
5. Gate-keeper roles and responsibilities	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	
6. Utilization and cost controls	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	
7. Capitation and fee-for-service rate setting	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	
8. Quality assurance/improvement processes	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	
9. Information needs and management information systems	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	
10. Medicaid and other third party eligibility determination	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	
11. Client grievances and appeals	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts	

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

2C. MANAGED CARE KNOWLEDGE AND CAPABILITIES: ACTION PLAN

Based on your discussions and the scores in Section 2, create an action plan about gaining more knowledge about managed care.

1. The Board needs to add members with expertise in:

_____

_____

_____

_____

_____

2. Management staff assigned to key managed care operational areas include:

_____

_____

_____

_____

_____

_____

_____

_____

3. Identify Board members and staff that need training in managed care and specify the type of training needed:

Board/Staff Member	Training Needed
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Technical assistance (TA) is needed in the following areas:

_____

_____

5. Resources to support training or TA:

Timeline: _____ Person Responsible: _____

3. CLINICAL MANAGEMENT OF HIV IN MANAGED CARE

Managed care plans are designed to finance and deliver health care. Some plans also cover limited support services because purchasers of care, such as State Medicaid programs, include those services in their benefit package. Plans may also cover some support services because they understand the importance of those services in achieving a continuum of accessible, high quality care. Regardless of the motivation for inclusion of support services, clinical care is the primary focus of managed care systems.

While adoption of managed care models has changed the health care market, advances in HIV drug development have greatly altered the clinical management of HIV and the HIV delivery system. It is important for your staff to understand the rapidly evolving HIV care and to identify roles that they can play in supporting HIV clinical care in a managed care environment. Managed care plans are more likely to contract or undertake linkage agreements with HIV support service agencies that can clearly articulate how their services help to sustain good health, prevent psychosocial crises that result in expensive clinical events, and support members' (i.e., clients') ability to adhere to HIV treatment. Moreover, HIV support service agencies have an important role in treatment advocacy and adherence support – a role that cannot be well fulfilled without understanding the treatment needs and regimens of their clients.

In this section, you will assess knowledge of your Board, management staff, and direct care providers regarding HIV clinical management and its implications for your clients' support service needs. Senior managers, direct service supervisors, and Board members should complete Section 2. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

3A. KNOWLEDGE REGARDING CLINICAL MANAGEMENT OF HIV

	Strongly Disagree Or Don't Know			*Strongly Agree*
1. At least twice annually, our agency provides or arranges for in-service training or other educational sessions about HIV clinical care (e.g., latest developments in clinical management, basic information regarding how HIV drugs work, developments in HIV drugs).	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
2. Our senior managers are knowledgeable about HIV clinical care.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
3. Our agency has undertaken strategic planning to identify ways in which we can support HIV clinical care.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
4. Our senior managers and/or direct service supervisors routinely meet with HIV clinicians in our community to plan ways to coordinate HIV clinical and support services.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
5. Our HIV direct service staff is knowledgeable about HIV clinical care.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
6. Our HIV direct service staff is knowledgeable about the role of HIV antiretrovirals and opportunistic infection treatment/prophylaxis in HIV care."	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
7. Our HIV direct service staff is knowledgeable about the need for adherence to HIV antiretrovirals and other drugs.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
8. The support services that our agency provides help our clients to adhere to their HIV care plan, including their use of HIV drugs and appointment keeping.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
9. Our HIV direct service staff routinely participate with HIV clinicians in case conferences or other coordination about our clients.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts

TOTAL POINTS [ ] DIVIDED BY NUMBER OF STATEMENTS ANSWERED [ ] EQUALS **SCORE** [ ]

Maximum possible score is 3.

3B. Clinical Management Of HIV: Action Plan

Based on your discussions and scores in Section 3, create an action plan for gaining knowledge about HIV clinical management.

1. The Board needs to add members with expertise in:

_____

_____

_____

Timeline: _____ Person Responsible: _____

2. Identify Board members and staff that need training regarding HIV clinical management:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. Identify HIV clinical programs or clinicians with whom your staff should initiate coordination of HIV clinical management and treatment adherence support:

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

4. TA is needed in the following areas:

_____

_____

5. Identify resources to support training or TA (e.g., AETC):

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

4. FINANCING OF HIV CARE

Your agency's staff should understand the major health care financing programs, or "third party payers," operating in your service area. This can be complex because payers are likely to have varied eligibility requirements and determination processes and diverse approaches to purchasing and regulating managed care systems.

Understanding the scope and nature of the managed care approaches and other policies of payers is important if your agency is to be an effective advocate for your clients. Payers are likely to have different approaches to providing care for HIV-infected beneficiaries. Their policies are also likely to vary regarding enrollment and disenrollment, access standards, coverage of services such as HIV drugs, rate setting and reimbursement methods, quality assurance, and grievance procedures. Your agency can play an effective role as an advocate for quality HIV care within managed care systems. Such advocacy should ideally be initiated at the earliest stages of the planning of managed care initiatives when undertaken by the State Medicaid agency. Advocacy must also be consistent during the evolution of managed care initiatives to help protect the interests of your clients.

Being well-informed about managed care plans is also critical if your agency is to develop a realistic managed care strategy. Plans differ widely in their experience in managing the care and cost of HIV. It is important for your agency to obtain information about the "HIV track record" of plans and their provider networks operating in your service area. Their HIV track record in other communities may also be informative.

Your agency should be aware of the eligibility criteria and determination processes adopted by public payers. Understanding these policies is critical to assure that your clients are optimally covered for health and ancillary care costs so that financial barriers to HIV care are minimized. Your agency must also understand eligibility policies so that processes are put into place to assist clients to enroll and maximize potential sources of third party revenue.

Your agency's managed care strategy should include a plan to: identify third party payers that might purchase your agency's services, estimate the number and service needs of existing and new clients who might enroll in a plan, identify services currently covered by the plans or for which they may wish to contract, develop a marketing plan, maximize revenue from payers, and make well-informed decisions about contracts and linkage agreements.

4A. THIRD PARTY INSURANCE ELIGIBILITY PROCESSES

Section 4a should be completed by senior managers, direct service supervisors, and staff responsible for eligibility determination for public funded insurance (Medicaid, Medicare, ADAP, Veterans, State health insurance pools) or commercial insurance. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Strongly Disagree Or Don't Know			***Strongly Agree***
Regarding assessing our clients' eligibility for public or commercial insurance:				
1. Our staff has formal assessment processes or routinely refers clients to another agency to undertake eligibility assessments (which includes review of income, clinical stage, employment status, and other criteria to identify potential sources of coverage).	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
2. At least once per quarter, our staff reassesses the eligibility of our clients or routinely refers clients to another agency to undertake eligibility reassessments.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
3. Our staff is knowledgeable about eligibility determination processes required to enroll clients or routinely refers clients to another agency to undertake determinations. ("Eligibility determination" means the formal administrative and clinical review of records by a governmental agency to ascertain an individual's status related to disability, income, employment history, or other criteria.)	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
4. We have ongoing contact with agencies conducting eligibility assessments or determinations for our clients to identify the outcome of those activities.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
5. Our clients' insurance coverage status is recorded in their files and updated after each change in coverage.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
6. At least annually, our agency provides or arranges for in-service training or other educational sessions about third party insurance eligibility criteria and determination processes.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

4B. KNOWLEDGE ABOUT MEDICAID MANAGED CARE AND OTHER POLICIES

Senior managers, direct service supervisors, and other relevant staff should complete Section 4b. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Strongly Disagree Or Don't Know			***Strongly Agree***
1. At least annually, our agency provides or arranges for in-service training or other educational sessions about Medicaid's new initiatives or policies on managed care, home and community-based waivers, coverage of services, or other topics.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
2. Our staff is knowledgeable about our State Medicaid Program's policies regarding which types of support services are covered by the Medicaid fee-for-service or home and community-based waiver programs.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
3. Our agency has reviewed the types of support services covered under the Medicaid fee-for-service program to determine whether our services can be reimbursed.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
4. Our staff is knowledgeable about the status of plans for implementation of Medicaid managed care initiatives in our service area.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
5. Our staff has identified the managed care plans operating in our service area that contract with our State's Medicaid program, including plans that have not begun enrolling members.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
6. Our staff has gathered information regarding the "HIV track record" of managed care plans in our service area that contract with our State's Medicaid program.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

4C. KNOWLEDGE ABOUT MEDICAID MANAGED CARE INITIATIVES

Senior managers, direct service supervisors, and other relevant staff should complete Section 4c. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Strongly Disagree Or Don't Know			***Strongly Agree***
Our staff is knowledgeable about State Medicaid policies on:				
1. Managed care, including primary care case management or voluntary or mandatory enrollment in managed care plans.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
2. Categories/populations required to participate in Medicaid managed care.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
3. Categories/populations *not* required to participate in Medicaid managed care.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
4. Provision of medical and ancillary services provided or financed by managed care plans (e.g., covered benefits and access standards).	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
5. Services that are "carved out" from the managed care benefits package and covered by Medicaid fee-for-service (e.g., case management, mental health services, substance abuse treatment).	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
6. Responsibilities of subcontractor agencies that participate in provider networks (e.g., credentialing, access standards, quality standards, reporting requirements).	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
7. Payment mechanisms and reimbursement rates from States to plans.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
8. Payment mechanisms used by plans for contracting agencies participating in provider networks that contract with managed care plans.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
9. Requirements to contract or establish linkage agreements with HIV support service agencies.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
10. Member and network provider grievance procedures.	❑ 0 pts	❑ 1 pt	❑ 2 pt	❑ 3pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

4D. KNOWLEDGE ABOUT OTHER MANAGED CARE INITIATIVES IN YOUR SERVICE AREA

Senior managers, direct service supervisors, and other relevant staff should complete Section 4d. Check the box with the score that best describes your level of agreement with the statements presented, and then add up your scores.

	Strongly Disagree Or Don't Know			***Strongly Agree***
1. Our staff has reviewed our clients' insurance enrollment data and other information and become knowledgeable about: other public and commercial managed care plans, including:				
• Publicly funded third party payers (e.g., Medicare, State health insurance risk pools) engaged in or planning to contract with managed care plans in our service area.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
• Employer-based commercial insurance companies that are engaged in or planning to contract with managed care plans in our service area.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
2. We have used our clients' insurance data and other information to identify managed care plans to which we can market our services.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
3. Regarding other public and commercial managed care plans operating in our service area, our staff is knowledgeable about:				
• Their "HIV track record."	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
• Types of support services they cover.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
• Responsibilities of subcontractor agencies that participate in the provider networks of managed care plans (e.g., credentialing, access standards, quality standards, reporting requirements).	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

4E. Financing Of HIV Care: Action Plan

Based on your discussions and scores in Section 4, create an action plan regarding financing and delivery of HIV care.

1. Third party eligibility assessment/determination processes that should be developed include:

_____
_____
_____
_____

Timeline: _____ Person Responsible: _____

2. Data needed from clients' insurance enrollment data include:

_____
_____
_____
_____

Timeline: _____ Person Responsible: _____

3. Information needed about the following Medicaid managed care and other policies:

_____
_____
_____
_____
_____
_____
_____

Timeline: _____ Person Responsible: _____

4. Information needed about Medicaid managed care plans includes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Timeline: _____ Person Responsible: _____

5. Information needed about other public or commercial managed care initiatives includes:

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

6. Information needed about managed care plans contracting with other public or commercial insurance companies includes:

_____

_____

_____

Timeline: _____ Person Responsible: _____

7. Training or TA is needed by:

Staff Member	**Training/TA Needed**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Timeline: _____ Person Responsible: _____

5. CAPACITY AND ACCESSIBILITY STANDARDS

Managed care plans commonly are required by State Medicaid programs, the federal Medicare program, or other purchasers of care to meet a set of requirements. In turn, managed care plans require providers in their network to meet these requirements. Requirements cover multiple areas, such as the provision of a set of covered services and ensuring continuity of care. Other requirements, which are assessed in Section 5, relate to *capacity* to serve clients (e.g., staff, resources) and *accessibility* (e.g., effective appointment system; provide 24-hour, 7 day per week coverage such as by telephone; accessible geographic and physical location). (Section 8 assesses another standard requirement: readiness to meet quality standards and cooperate with quality assurance activities.)

Results of this assessment will help your agency to identify weaknesses that require improvement as well as identify strengths that will be useful in marketing the services of your agency to managed care plans.

Senior managers, direct service supervisors, and other relevant staff should complete Section 5.

5A. CAPACITY

An important reason for establishing a contract or linkage agreement with a managed care plan is to retain access to your client base. Establishing a relationship with a plan may also result in referrals of new clients to your agency. Under a contractual arrangement with a plan, increased volume should result in increased revenue to your agency. Alternatively, increased referrals gained through linkage agreements in which no income is earned by your agency may result in high caseloads, rapid depletion of finite resources (e.g., transportation vouchers), and insufficient funds. It is important to consider the tradeoffs between gaining enrollment and the fiscal impact on your agency and staff. In assessing capacity it is important to account for current clients and increased caseloads due to newly infected individuals and/or referrals from plans.

Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Strongly Disagree Or Don't Know → ***Strongly Agree***			
1. Our HIV program has sufficient capacity to meet the support service needs of our **current** client load based on the following criteria:				
• Staffing (e.g., direct service providers, clerical personnel, other support staff).	❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
• Physical capacity (including offices, interview rooms, and client waiting room space).	❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
• Resources (e.g., telephones and telephone lines, transportation vouchers, supplies).	❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
2. Our HIV program has sufficient capacity to meet the support service needs of **an increased client load** based on the following criteria:				
• Staffing;	❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
• Physical capacity;	❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts
• Resources.	❑ 0 pts	❑ 1 pt	❑ 2 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

5B. ACCESSIBILITY STANDARDS: COVERAGE

Accessibility standards in most managed care plans require contracting providers to be open for a minimum number of hours. Plans also require providers of essential services (e.g., clinical, case management) to have a 24-hour, seven-day per week live coverage system to provide accessible care, prevent crises, and decrease unnecessary emergency room use. Accessibility standards are commonly defined in contracts between purchasers, such as a State Medicaid program, and managed care plans. Model contracts may be obtained from the State Medicaid program or through a plan's provider relations office. They may also be available via the State Medicaid Program's Internet web site.

Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
1. The number of hours our agency is open meets Medicaid requirements for providers in health plan networks.	❑ 0 pts	❑ 0 pts	❑ 3 pts
2. Our agency has a live 24-hour coverage system that includes access to a provider when the agency is not open.	❑ 0 pts	❑ 0 pts	❑ 3 pts
3. Information from the telephone coverage system is entered into the client's record maintained by our agency.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

5C. ACCESSIBILITY STANDARDS: APPOINTMENT SYSTEM

To participate as a network provider, Medicaid and other purchasers may require that your agency's appointment system meet certain standards. These often include standards regarding the number of days it takes to get an appointment, a maximum time that it takes for a client to schedule an appointment over the telephone, and provision of a specific time and staff person for the appointment. There may also be requirements regarding practices that assist clients to keep or follow-up on their appointments. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
1. The number of minutes it takes for a client to reach a staff person by telephone at our agency to make an appointment meets the standard set by managed care plans.	❑ 0 pts	❑ 0 pts	❑ 3 pts
2. For a new **non-urgent** client, the number of days a client must wait for an appointment at our agency meets the standards set by managed care plans.	❑ 0 pts	❑ 0 pts	❑ 3 pts
3. For a new **urgent** client, the number of days a client must wait for an appointment at our agency meets the standards set by managed care plans.	❑ 0 pts	❑ 0 pts	❑ 3 pts
4. Our agency's appointments are provider and time specific.	❑ 0 pts	❑ 0 pts	❑ 3 pts
5. For a client who has an appointment, the average waiting time to see a provider from the time the client registers at our reception area meets the standards set by managed care plans.	❑ 0 pts	❑ 0 pts	❑ 3 pts
6. Our clients receive verbal and/or written reminders of their upcoming appointments.	❑ 0 pts	❑ 0 pts	❑ 3 pts
7. Our staff follows up with clients by mail or telephone about missed appointments.	❑ 0 pts	❑ 0 pts	❑ 3 pts
8. Our staff conducts home visits to follow-up with clients that have missed appointments.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3

5D. ACCESSIBILITY STANDARDS: TELEPHONE AND RECEPTION

Telephone and reception policies may be reviewed by managed care plans to assess your responsiveness to clients. It is important for telephone and reception staff to be trained in and knowledgeable about managed care policies and procedures. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
1. Our reception staff receives in-service training at least once per year regarding our agency's telephone and reception policies.	❑ 0 pts	❑ 0 pts	❑ 3 pts
2. Our agency has a written telephone policy for triaging clients to a staff member.	❑ 0 pts	❑ 0 pts	❑ 3 pts
3. There is an emergency telephone number automatically provided during office hours if a client is put on hold or connected to our voice mail system.	❑ 0 pts	❑ 0 pts	❑ 3 pts
4. Our reception staff routinely verifies any changes in a client's insurance status.	❑ 0 pts	❑ 0 pts	❑ 3 pts
5. Our reception staff routinely obtains referral paperwork when a client arrives for an appointment.	❑ 0 pts	❑ 0 pts	❑ 3 pts
6. Our agency has mechanisms to communicate with clients who have limited on no English speaking skills.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

5E. ACCESSIBILITY STANDARDS: GEOGRAPHIC AND PHYSICAL LOCATION

Your geographic location and proximity to other providers in a plan's network, their members, and public transportation routes may be reviewed by managed care plans to assess your agency's physical accessibility. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
1. Our agency is located in a geographic area that is easily accessible to the majority of the clients we serve.	❑ 0 pts	❑ 0 pts	❑ 3 pts
2. Our agency is located in reasonable proximity to major thoroughfares and public transportation routes.	❑ 0 pts	❑ 0 pts	❑ 3 pts
3. Our agency's building has sufficient parking for clients in reasonable proximity to our building.	❑ 0 pts	❑ 0 pts	❑ 3 pts
4. Our agency provides free parking or parking tokens/vouchers to our clients.	❑ 0 pts	❑ 0 pts	❑ 3 pts
5. Our agency's building is physically accessible to the handicapped.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

5F. ACCESSIBILITY STANDARDS: CLIENT ACCEPTABILITY

Medicaid and other purchasers of care often require that client/patient satisfaction be measured on a regular basis. Satisfaction surveys are a source of information regarding the acceptability of your agency's services. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
1. Our agency conducts a client/patient satisfaction survey at least once per year.	❑ 0 pts	❑ 0 pts	❑ 3 pts
2. Our agency has other mechanisms to obtain consumer input.	❑ 0 pts	❑ 0 pts	❑ 3 pts
3. During our agency's busiest days and times, there is a sufficient number of chairs in our waiting room for clients.	❑ 0 pts	❑ 0 pts	❑ 3 pts
4. Our waiting room is clean, uncluttered, safe, and presentable.	❑ 0 pts	❑ 0 pts	❑ 3 pts
5. Separate rooms or other soundproof areas are available for staff to meet with clients.	❑ 0 pts	❑ 0 pts	❑ 3 pts
6. Direct service providers, receptionists, and appointment staff are available to communicate with clients in languages other than English.	❑ 0 pts	❑ 0 pts	❑ 3 pts
7. Written materials regarding our services and education materials are available in languages other than English.	❑ 0 pts	❑ 0 pts	❑ 3 pts
8. Our agency has a system in place to monitor and respond to client complaints.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

5G. ACCESSIBILITY STANDARDS: ACTION PLAN

Based on your discussions and scores in Section 5, create an action plan regarding meeting accessibility standards.

1. Steps to be taken to meet coverage standards include:

_____

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

2. Steps to be taken to meet appointment standards include:

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

3. Steps to be taken to meet telephone and reception standards include:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

4. Steps to be taken to meet geographic location standards include:

_____

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

5. Steps to be taken to meet client acceptability standards include:

_____

_____

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

6. Training or TA is needed by:

Staff Member	**Training/TA Needed**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

7. Resources needed to undertake the activities identified in the Action Plan:

_____

_____

_____

_____

_____

6A. FINANCIAL MANAGEMENT: ACCOUNTING SYSTEMS

Agencies contracting with managed care plans should assume financial risk only for those services for which they have direct management and fiscal control. Your agency's financial management capabilities are extremely important to a successful partnership with managed care plans. You will need to have systems in place, including an accounting system to manage costs. Your financial and accounting system must be designed to adequately support managed care financial activities—specifically to provide information to manage and control your capitated health care activities.

Your agency's Director of Finance or other staff member responsible for this function should complete Section 6. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
Our accounting system can:			
• Segregate prepaid and fee-for-service accounting centers;	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Track costs of capitated services;	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Identify clients by payment source;	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Generate bills for non-covered services and co-payments; and	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Handle accrual accounting.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

6B. UNIT COST AND RATE SETTING

If your agency enters into a capitated arrangement with a managed care plan, you will need to have information to support initial fee-for-service or capitation rate negotiations. Following contracting, you will need to monitor revenue to assess its adequacy. Capitation rate setting and other financial risk bearing arrangements are complex and outside the scope of this guide. If risk-bearing arrangements are considered by your agency, it is important to obtain expert consultation before execution of contracts with plans. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Strongly Disagree Or Don't Know			***Strongly Agree***
1. Our staff is well trained and experienced in computing our agency's unit costs.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
2. Our staff understand the data required to compute unit costs.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
3. Our accounting and other information systems generate accurate unit cost data.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
4. Our staff is well trained and experienced in computing per capita monthly costs by the type of service provided by our agency.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
5. Our MIS uses standard procedure and disease coding systems such as ICD-9-CM and CPT codes.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts
6. Our staff is trained in basic concepts of capitated rate setting.	❑ 0 pts	❑ 1pt	❑ 2 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

6c. Financial Management: Action Plan

Based on your discussions and scores in Section 6, create an action plan regarding financial management.

1. Redesign financial and other information systems by:

_____

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

2. Produce the following unit cost, per capita utilization and cost, and other reports:

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

3. Training or TA is needed by:

Staff Member	Training/TA Needed
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Timeline: _____ Person Responsible: _____

4. Resources needed to undertake the Action Plan:

_____

_____

_____

_____

_____

7. MANAGEMENT INFORMATION SYSTEM (MIS)

To succeed in a managed care environment, your agency's Board of Directors, managers, and direct service staff must have data that are accurate, relevant, readily available, and timely. As a network provider, your agency will also be responsible for data collection and reporting to managed care plans.

In planning for participation in managed care provider networks, your agency's capacity to generate, analyze, and understand data is critical. Data are needed at each step in the development of your agency's managed care product line. When your agency becomes a managed care network provider, data are needed to monitor your costs, assess your financial risk, understand your client's utilization patterns, evaluate the quality of services provided, and assess the practice behavior of your staff. Data will also be needed to meet managed care plan reporting requirements regarding membership, capitation, utilization, quality, and staff practice behavior.

Your agency's MIS Director or other staff member responsible for this function should complete Section 7.

7A. AGGREGATE UTILIZATION AND COST DATA

Health care utilization and cost data, on an aggregate or summary basis, need to be monitored monthly. Aggregate reports provide an overview of utilization and cost patterns and can be used to compare actual to projected utilization and costs. In addition to summary reports, it is important to be able to track service utilization and costs for specific groups of clients by payer type (e.g., Medicaid and commercial managed care plans) and by type of service unit provided (e.g., case management visit).

Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
Our MIS includes or can be used to generate the following data:			
• Payment sources (overall);	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Payment sources by patient;	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Appointments scheduled, kept, rescheduled, and broken;	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Total number of units of service rendered by type of service;	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Total number of units of service, by service type, per member per month;	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Total cost per type of unit of service;	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Cost per visit by type of unit of service; and	❑ 0 pts	❑ 0 pts	❑ 3 pts
• Total cost of units of service rendered by type of service.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

7B. DATA COLLECTION SYSTEMS

It is critical that the data maintained in your MIS is collected in a reliable manner. Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
1. Our data abstraction staff has received formal academic training in health care record abstraction.	❑ 0 pts	❑ 0 pts	❑ 3 pts
2. Our staff receives training at least annually regarding data collection and computer entry policies and procedures—including issues related to confidentiality of patient records.	❑ 0 pts	❑ 0 pts	❑ 3 pts
3. We have mechanisms in place to assure the accuracy of the data abstracted and entered into databases.	❑ 0 pts	❑ 0 pts	❑ 3 pts
4. We use standardized data collection instruments to abstract information from clients' billing and service records.	❑ 0 pts	❑ 0 pts	❑ 3 pts
5. Data quality procedures are in place to verify the accuracy of the information abstracted and automated from clients' billing and service records.	❑ 0 pts	❑ 0 pts	❑ 3 pts
6. Longitudinal data are collected, automated, and stored to identify changes over time such as changes in insurance status, clinical stage, etc.	❑ 0 pts	❑ 0 pts	❑ 3 pts
7. We maintain records describing the structure of the data in our MIS (e.g., data dictionaries).	❑ 0 pts	❑ 0 pts	❑ 3 pts
8. Our agency is able to meet its current reporting requirements on time and in a manner requested by our funding sponsors.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

7c. Computer Hardware, Software, and Staff Analytic Capabilities

Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
1. Our computer hardware system meets the data collection, storage, and analytic needs of our management, fiscal, direct service, and clerical staff.	❑ 0 pts	❑ 0 pts	❑ 3 pts
2. Most of our personal computer system was purchased or upgraded within the past two years.	❑ 0 pts	❑ 0 pts	❑ 3 pts
3. Our MIS staff receives in-service training or other formal training at least annually in the use of our computer hardware and software systems.	❑ 0 pts	❑ 0 pts	❑ 3 pts
4. The software maintained in our MIS was purchased within the past two years.	❑ 0 pts	❑ 0 pts	❑ 3 pts
5. Our management and direct service staff receives in-service or other formal training at least annually in the use of our computer system.	❑ 0 pts	❑ 0 pts	❑ 3 pts
6. Our staff is professionally trained in the application of basic statistical and other quantitative methods to produce reports.	❑ 0 pts	❑ 0 pts	❑ 3 pts
7. Standard reports produced using the databases maintained by our agency are timely and accurate.	❑ 0 pts	❑ 0 pts	❑ 3 pts
8. Standard reports produced by our staff meet our agency's management needs.	❑ 0 pts	❑ 0 pts	❑ 3 pts
9. Standard reports produced by our staff meet the needs of our direct service staff.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

7D. MIS: ACTION PLAN

Based on your discussions and scores in Section 7, create an action plan regarding MIS.

1. Actions needed to redesign or upgrade your MIS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

2. Training or TA is needed by:

Staff Member	**Training/TA Needed**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Timeline: _____ Person Responsible: _____

3. Resources needed to undertake the Action Plan:

_____

_____

_____

_____

_____

_____

8. Quality Assurance (QA) and Utilization Management Activities

Monitoring the quality and use of services rendered to managed care enrollees and taking immediate corrective action when needed is of critical importance to a successful experience with managed care. To accomplish this, your agency should have a QA and utilization management plan. The nature and extent of such a plan is likely to vary based on the contractual requirements of Medicaid or other purchasers, as well as requirements of other funding sponsors such as HRSA. Information regarding the QA and utilization management requirements of the plans operating in your service area may be obtained from model contracts established by the State Medicaid program or managed care plans' provider relations department. It should be noted that payers may not specifically set quality standards for HIV support services for managed care plans unless these are covered services.

Senior managers, quality assurance staff, or direct service staff should complete Section 8.

8A. Quality Assurance And Utilization Management

Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
1. Our agency has a written QA and utilization management plan that documents policies, procedures, and protocols.	❑ 0 pts	❑ 0 pts	❑ 3 pts
2. Our direct service staff receives in-service training at least once per year regarding our agency's QA and utilization plan.	❑ 0 pts	❑ 0 pts	❑ 3 pts
3. Continuous quality improvement techniques are undertaken by our agency to identify and correct systematic problems in quality and utilization.	❑ 0 pts	❑ 0 pts	❑ 3 pts
4. Based on our agency's QA and utilization management plan, management staff meets with direct service providers to review performance and identify inappropriate utilization and cost patterns.	❑ 0 pts	❑ 0 pts	❑ 3 pts
5. Our agency has a feedback process to change inappropriate staff practice patterns.	❑ 0 pts	❑ 0 pts	❑ 3 pts
6. Our management staff routinely enforces decisions in the event of inappropriate staff practice patterns.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

8B. CREDENTIALING

Check the box with the score that best describes your level of agreement with the statements presented. Then add up your scores.

	Don't Know	*No*	*Yes*
1. Our agency maintains the relevant facility licenses required in our State and local jurisdictions.	❑ 0 pts	❑ 0 pts	❑ 3pts
2. Our agency has not been suspended or excluded from participating in Medicare, Medicaid, or other health insurance programs.	❑ 0 pts	❑ 0 pts	❑ 3 pts
3. Our agency maintains a current malpractice or liability coverage policy.	❑ 0 pts	❑ 0 pts	❑ 3 pts
4. Our senior managers understand State and professional licensure and credentialing requirements for professional staff employed by our agency.	❑ 0 pts	❑ 0 pts	❑ 3 pts
5. The licenses and other credentials of the professional staff employed by our agency are verified using primary source documents.	❑ 0 pts	❑ 0 pts	❑ 3 pts
6. The licenses and other credentials of the professional staff employed by our agency are current.	❑ 0 pts	❑ 0 pts	❑ 3 pts
7. The continuing education requirements for licensure or credentialing of professional staff employed by our agency are up-to-date and verified using primary source documents.	❑ 0 pts	❑ 0 pts	❑ 3 pts

TOTAL POINTS ☐ DIVIDED BY NUMBER OF STATEMENTS ANSWERED ☐ EQUALS **SCORE** ☐

Maximum possible score is 3.

8C. QA AND UTILIZATION MANAGEMENT ACTIVITIES: ACTION PLAN

Based on your discussions and scores in Section 8, create an action plan regarding QA and utilization management.

1. Areas in your QA and utilization management policies and practices that require modification:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Timeline: _____ Person Responsible: _____

2. Training or TA is needed by:

Staff Member	**Training/TA Needed**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Timeline: _____ Person Responsible: _____

3. Identify resources needed to undertake the Action Plan:

_____

_____

_____

_____

_____

9. Readiness Summary Score: Putting It All Together

The Score Sheet is used to summarize the scores in each of the eight sections. Included is a column of the Total Possible Score that could be assigned in each section. Transfer your summary scores from each section under the column Your Agency's Score. Check your math!

There is no ideal readiness score. The higher your agency scored, the more prepared your agency is likely to be. There is probably room for improvement in at least some of the dimensions of readiness. For each section, if Your Agency Score is below the Total Possible Score, identify individual statements that scored below 2 and consider them in your agency's managed care strategic planning and organizational development activities conducted in preparation for managed care participation.

Following completion of the Score Sheet, review the results with the staff of your agency that are engaged in managed care strategic planning. In developing your strategic plan, the results of the Action Plans from each section can be used as an outline. The plan should also include a time line for completion of each action step and staff work assignments.

Requests for training and TA should also be summarized and resources identified to address needs. Resources include HAB's technical assistance services and AIDS Education and Training Centers (AETCs) (see **http://hab.hrsa.gov**); TA initiatives being supported by various agencies within HRSA (like the HRSA Center for Health Services Financing and Managed Care at **http://www.hrsa.gov/financeMC/**); and training programs being offered by State/local governments and HIV or other associations. See HAB's website at **http://hab.hrsa.gov** to identify these and other resources or contact your project officer.

Section	Total Possible Score	Your Agency's Score	Action Plans to Develop
1. Knowledge And Capabilities			**Managed Care Knowledge/Capabilities**
1a. Knowledge And Capabilities In Areas Of Interest To Managed Care			
2a. Understanding Managed Care Concepts: Board of Directors	**3**		
2b. Understanding Managed Care Concepts: Management and Direct Services	**3**		
3. Clinical Management of HIV			**Clinical Management of HIV**
3a. Knowledge Regarding Clinical Management of HIV	**3**		
4. Financing of HIV Care			**Financing of HIV Care**
4a. Third Party Insurance Eligibility Processes	**3**		
4b. Knowledge About Medicaid Managed Care And Other Policies	**3**		
4c. Knowledge About Medicaid Managed Care Initiatives	**3**		
4d. Knowledge About Other Managed Care Initiatives In Your Service Area	**3**		
5. Capacity and Accessibility Standards			**Accessibility Standards**
5a. Capacity	**3**		
5b. Accessibility Standards: Coverage	**3**		
5c. Accessibility Standards: Appointment System	**3**		
5d. Accessibility Standards: Telephone And Reception	**3**		
5e. Accessibility Standards: Geographic And Physical Location	**3**		
5f. Accessibility Standards: Client Acceptability	**3**		
6. Financial Management			**Financial Management**
6a. Accounting Systems	**3**		
6b. Unit Cost And Rate Setting	**3**		
7. Management Information System			**MIS**
7a. Aggregate Utilization And Cost Data	**3**		
7b. Data Collection Systems	**3**		
7c. Computer Hardware, Software, And Staff Analytic Capability	**3**		
8. Quality Assurance And Utilization Management Activities	**3**		**QA and Utilization Management**
8a. Quality Assurance And Utilization Management	**3**		
8b. Credentialing	3		
TOTAL	**69**		

10. APPENDIX

ASSESSING MANAGED CARE PLAN PARTNERS

Managed care plans vary widely in their approaches to care and financing. It is important to identify the key strengths and weaknesses of each plan, how these attributes complement your agency's attributes, the needs of the plan that your agency might fulfill, and the expectations the plan has for network providers. The table below will assist you to compare managed care plans. List the major plans operating in your service area (including plans that your agency already contracts or has linkage agreements with). Information needed to complete this table may be obtained from HIV needs assessments, other community surveys, the State insurance commissioner, Medicaid program, managed care plans, HIV clinician surveys, the plan's Medical Director, or other sources.

PLAN CHARACTERISTICS	*NAME OF PLAN*			
GREATEST MARKET SHARE OF HIV-INFECTED INDIVIDUALS	❑	❑	❑	❑
GREATEST % OF MEDICAID ENROLLMENT	❑	❑	❑	❑
GREATEST COMMITMENT TO HIV-INFECTED INDIVIDUALS	❑	❑	❑	❑
MOST ESTABLISHED TRACK RECORD IN QUALITY HIV CARE	❑	❑	❑	❑
BEST TRACK RECORD WITH CLIENTS	❑	❑	❑	❑
BEST TRACK RECORD WITH HIV CLINICIANS	❑	❑	❑	❑
GREATEST INTEREST IN LINKING WITH HIV SUPPORT SERVICE AGENCIES	❑	❑	❑	❑
BEST FINANCIAL POSITION	❑	❑	❑	❑