

SECTION 2. CONTRACT REQUIREMENTS

A. Advances

Per the Department of Financial Services (DFS), all requests for advances on contracts must state the time period of the advance and a brief statement justifying the cash needs for the advance per Florida Statute 216.181(16) and Department of Health Policy 250-14-07. Submit the criteria for advance requests on agency letterhead, total contract amount and dates required.

- The following is from section 216.181(16)(b) F.S.:
...The amount that may be advanced shall not exceed the expected cash needs of the contractor or recipient within the initial 3 months...
- The following is from DOHP 250-14-07 (VII.H.7.a):
a. *Payment of Advances.* Such advances may be made on a monthly basis up to the first three months of the contract and may not exceed the expected cash needs of the provider during the first three months.
Detailed documentation justifying cash needs for advances (certified statement/work-papers from provider analyzing the timing of projected expenditures versus available operating and anticipated revenues) must be maintained in the contract manager's file.

DFS continues to monitor contract payments very closely to ensure they are in compliance with the terms and conditions and method of payment schedule contained in the contract language. All contract managers must be aware whether or not payments submitted to Finance and Accounting meet those requirements.

If a lead agency is requesting an advance payment, please include information similar to that below on each invoice.

The expected cash needs for contract COD__ are as follows: We have calculated the costs for the time period of _____ through _____, 20___. The calculations are based on historical costs for the categories listed.

Direct Care	\$ _____
Administration	\$ _____
Program Support	\$ _____
Total Monthly Average	\$ _____
\$ (<u>monthly average</u>) X 3 months =	\$ _____

Our request for advances is a total of \$ _____. These advances will allow the (Name of Provider) to pay providers for services delivered for the above listed time period.

Each invoice for Advance Payment Requests must show the justification and calculations on how they arrived at the amount. The amount to be advanced shall not exceed the expected cash needs of the provider for the initial three months of the contract.

All requests for advances must be approved by the deputy secretary of the department. When submitting an invoice that contains a request for an advance, allow time for the processing of this additional approval.

B. Subcontractors

The provider, if permitted to subcontract for all or part of the services under a contract, must adhere to the following guidelines:

- All subcontracts from prior years will expire and must be renewed consistent with the new Ryan White Part B contract year of April 1 through March 31 or the General Revenue Patient Care Network contract year of July 1 through June 30.
- No subcontracts are to be executed prior to execution of the primary contract between the provider and the department.
- All subcontracts are to be executed no more than 90 days after the execution of the primary contract. Services and payment for subcontracted services cannot begin prior to the execution of a signed contract. It is recommended that contract negotiations begin three to four months prior to the beginning of the respective contract year so there is no delay in services.
- All subcontracts must contain language and restrictions similar to the primary contract including scope of work, which includes key activities/services to be rendered and documentation required to substantiate the delivery of service.
- Lead fiscal agencies must ensure that subcontracts are in compliance with the primary contract and must complete the following forms as part of the subcontract process:
 - Certificate Regarding Lobbying
 - Civil Rights Checklist
 - Certificate Regarding Debarment and Suspension
 - Federal Sub Recipient and Vendor Determination Checklist
 - Documentation of Non-Competitive Procurement (if applicable)
 - IRS form W-9 (<http://www.irs.gov/pub/irs-pdf/fw9.pdf>)
- Part B and PCN providers are required to report information on subcontracts using the Ryan White Part B or PCN subcontractor/provider list. The requested information must be submitted to the department through the AIDS Information Management System (AIMS), consistent with the reporting requirements in Section 4.
- **For Patient Care Part B and PCN contracts and subcontracts, the allocation of indirect costs to services category line items is not allowable.** It is allowable to allocate up to 10 percent of the total contract amount to administrative costs, which include such items as supplies, rent, utilities and other costs necessary to the administer the contracted program. There are situations where some or all of an administrative cost may be allocated to a direct service line if that cost is part of the provision of direct client services. An example would be supplies or facilities costs that are directly related to the provision of client services. When the cost is properly placed in the direct care line item, it would then be considered part of the direct cost for that service category. It must be noted that all costs assigned to a service line item will be

calculated as part of the unit cost for reporting purposes and, as such, only those costs that can be clearly identified as necessary to the provision of direct services should be placed in the service line item. If a contractor or subcontractor uses a formula to calculate the portion of administrative costs associated with direct service categories, they must provide, in writing, the formula used to calculate these costs. **Contract managers will be responsible for reviewing contractors' and subcontractors' calculations and documentation related to these costs.**

The Office and Management and Budget (OMB) Circular No. A-122 provides guidance on determining how these costs are documented.

http://www.whitehouse.gov/omb/assets/omb/circulars/a122/a122_2004.pdf.

Lead fiscal agencies are responsible for ensuring that subcontractors, especially new subcontractors, have sufficient infrastructure to support their contracts and meet their deliverables. Options for assessing the viability of subcontractors include reviewing the organization's most recent audit or performing an administrative assessment. A sample administrative assessment form is included as Appendix C, which can be adapted for local use. The assessment can be performed by the lead fiscal agency or an entity engaged by the lead agency for this purpose.

Contract managers may also use the assessment tool to evaluate the lead agency, especially if there are questions regarding the lead agency's financial viability.

C. Monitoring

1. Lead Agencies

Contract managers must monitor all lead agency contracts and lead agency memoranda of agreement twice a year. Patient Care is piloting a new contract monitoring schedule to afford contract managers the opportunity to review the lead agency's first Quarterly Financial Report prior to the first monitoring and still allow time to identify and correct problems. Therefore, the first contract monitoring should be completed after the receipt of the provider's first Quarterly Financial Report (due 30 days after the end of the first quarter) but no later than 135 days after the start of the contract and once between the last 90 to 60 days of the contract. Lead agency memoranda of agreement are monitored by the Bureau of HIV/AIDS Community Programs Coordinators acting as the contract manager for these agreements.

The need for corrective actions discovered during a monitoring must be clearly noted along with a reasonable time frame allowed for resolution. Documentation reflecting resolution of corrective action(s) must be reported to contract manager.

For department contract managers, a monitoring template is provided on the shared drive under the folder labeled "Monitoring Templates." The template should be modified to reflect any additional contract provisions and providers specific to an area. **In the column "Ratings Based Upon," all provisions must be verified either by direct observation by the contract manager or by supporting documentation. Interviews will no longer be accepted.**

All lead agency monitorings should be scanned in PDF format and placed in the "Completed Contract Monitorings" folder on the shared drive.

During each contract monitoring of the lead agencies, the following provisions must be verified:

- Provider has an accounting process that is effective in tracking and reporting monthly expenditures.
- Service delivery supporting documentation has been maintained and/or submitted as defined by the contract.
- A percentage of cancelled checks reviewed ensure dates on each check match the "paid" date on the invoice.
- Accounting procedures are in place that analyze encumbrances and expenditures and assist the provider in making budget projections on future line item allocations.
- Provider has a procedure in place to encumber authorized care services for each service agency and track those encumbrances.
- Invoices are accurate, complete and submitted on time as defined by the contract.
- Invoices submitted are for allowable services only and that the expenses are charged to the correct line item.

2. Monitoring of Subcontracted Providers

Lead agencies are responsible for:

- Providing a list of projected monitoring dates to contract manager within 30 days of the start of contract.
- Monitoring subcontracted providers for compliance with the subcontract and providing the monitoring reports to the department contract manager within the first 120 days of the contract.
- Supporting subcontracted providers with technical assistance as needed.

Monitoring templates for case management and eligibility are provided to all lead agencies via email and on the shared drive for contract managers.

D. Medical and Non-Medical Case Management

The HIV/AIDS Case Management Operating Guidelines provide the operating guidelines for case management service providers funded by the Florida Department of Health, Bureau of HIV/AIDS. (http://www.doh.state.fl.us/Disease_ctrl/aids/care/casemgmt.html) Lead agencies must ensure subcontracted agencies comply with the training and monitoring requirements established by the department and are responsible for disseminating appropriate department medical case management policies, procedures and documents to the medical case management agencies for distribution to appropriate staff.

1. Programmatic Information

Case management represents a large portion of the Patient Care Program allocations each year. Improved fiscal and program accountability continues to be emphasized to ensure continued funding and service delivery.

Note: Section 3 of this document presents an additional funding source for case management staff under "Section C. Clinical Quality Management Budget."

2. Definitions

For purposes of the Patient Care Program services contracts, the definitions for Medical case management and Case management (non-medical) are taken from the Ryan White HIV/AIDS Treatment Modernization Act of 2006 Definitions for Eligible Services:

Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact and any other forms of communication.

Case management (non-medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments as medical case management does.

This case management definition in the Support Service category is for services provided to clients who do not need the comprehensive services (five key activities) required for medical case management. It provides an option for lead agencies and case management agencies to serve clients who need advice and assistance in obtaining needed services, but not the comprehensive services provided by medical case management.

This is a flexible funding category and is used to fund case management, support staff or other staff with specific expertise to provide the assistance and advice to clients as defined above. Please note that eligibility determination is defined as a support service under case management (non-medical) and is not considered to be an administrative cost.

See Section 3 for detailed instructions for completing the case management budget narrative.

E. Outcome/Output Measures

An outcome is a benefit of a service to an individual and/or to the community, usually expressed as improved condition, modified behavior, changed attitude/values or increased skills or knowledge. They typically relate to social and/or health benefits. Outcomes are measured through specific indicators that assess achievement and level of success and should be understandable, available, feasible, reliable and valid.

Outcomes in the contract should meet the following criteria:

- Easy to verbalize
- Be measurable
- Be attainable

- Be a direct result of an intervention
- Be an accepted result of the program
- Be a meaningful benefit for the population served

Outcome indicators:

- Identify a unit of measurement
- Measure an important aspect of a service/program
- The wording is clear and specific
- Identify an accomplishment or desired change
- Changes can be expressed as knowledge, skill or behavior

An output is an actual service or product delivered by the provider. Program tasks transform inputs into outputs. Examples are:

- The increased number of clients referred to compassionate care pharmaceutical programs
- The increased number of clients linked back into care
- An increased number of clients compliant with a medication regimen
- A reduced number of clients missing doctor's appointments

Measurable outcome and output data are an indication that the objectives have been achieved. Measures enable you to evaluate whether the program has been successful and to what degree.

In accordance with Department of Health Policy 250-14-07, Contractual Services Policies and Procedures, all contracts entered into by the department shall contain a set of objective performance measures and standards by which the contract provider's performance may be evaluated. All performance-based contracts shall contain specific outcome/output measures and will include a clear description of the monitoring and evaluation activities.

For the 2010-11 contract year, each area is required to develop a minimum of one outcome/output measure for each core service funded by the contract. For the purposes of the Part B and PCN contracts, core services are defined as:

- AIDS Pharmaceutical Assistance (local)
- Ambulatory/Outpatient Medical Care
- Early Intervention Services
- Health Insurance Premium/Cost Sharing Assistance
- Home and Community-Based Health Services
- Home Health Care
- Hospice Services
- Medical Case Management Services (including treatment adherence)
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Substance Abuse Services (outpatient)

These outcome/output measures are to be added to the contract in Part A, Section E. If a contract does not fund a core service, outcome/output measures should be written for the support service categories receiving the largest portion of the funding.

If a contract only funds one service, a minimum of two measures per contract is required.

F. HRSA's HIV/AIDS Core Clinical Performance Measures

HRSA's HIV/AIDS Bureau (HAB) developed a set of HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents for use in monitoring the quality of care provided that can be used for direct service categories that include ambulatory/outpatient care, oral health care, mental health services, treatment adherence, substance abuse services and health education/risk reduction. HRSA released the measures in phases to allow for staged implementation. If a program has no performance measures, Group 1 measures (<ftp://ftp.hrsa.gov/hab/habGrp1PMs08.pdf>) provide an excellent start and can serve as a foundation on which to build. Group 2 measures (<ftp://ftp.hrsa.gov/hab/habGrp2PMs08.pdf>) are important measures for robust clinical management, which programs should seriously consider. Group 3 measures (<ftp://ftp.hrsa.gov/hab/PMgroup3.pdf>) represent areas of care that exemplify best practices, but it may be difficult to collect data due to the lack of written clinical guidelines.

The performance measures represent key clinical decision points and should be included as part of a quality management program for those providing services to the HIV-infected population. While HRSA does not require data submission at this time, Ryan White programs are **strongly encouraged** to track and trend data on these measures to monitor the quality of care provided. **These measures will become mandatory in contract year 2011-12.** When HRSA requires data submission, it will be the responsibility of the lead agencies to provide this data to the Florida Department of Health, Bureau of HIV/AIDS. HRSA's core clinical performance measures can be found at <http://hab.hrsa.gov/special/habmeasures.htm#performance1>.

To assist Ryan White programs in the use and implementation of the core clinical performance measures, HRSA developed a reference guide: HIV/AIDS AIDS Bureau's (HAB) HIV Core Clinical Performance Measures for Adults and Adolescents: Companion Guide at <ftp://ftp.hrsa.gov/hab/habPMsGuide09.pdf>. Additionally, within CAREWare, the Performance Measurement Module (PMM) has been created and is available for use. The PMM allows the user to enter and tabulate data for HAB's Group 1 and Group 2 measures. Further measures may be added at a later point. It is important to note that CAREWare allows the user to customize performance measures. Therefore, any of HAB's measures can be added or new measures can be created.

G. Fee for Service

In accordance with Part B.10 of the contract, "Manner of Service Provision," co-payments shall be assessed when practicable. If assessed, fees must be reinvested into the HIV program. Refer to Appendix D for details.