

SECTION 2. CONTRACT REQUIREMENTS

A. Eligibility for Services

All clients receiving services from Ryan White Part B, General Revenue Patient Care Network or other programs administered by the Bureau of HIV/AIDS must be determined eligible based on [Chapter 64D-4](#), Florida Administrative Code. **All contracted providers that determine eligibility are required to enter eligibility information on every client into the eligibility module in CAREWare.**

It is the responsibility of the agency that determines a client's eligibility to ensure that this process is done correctly. If it is later found that a client was erroneously determined eligible, the determining agency will be liable for the cost of services provided to that client. Additionally, contract managers that perform eligibility file reviews must determine the rate of error (percentage of clients that were incorrectly determined eligible) for each agency. Agencies that have an error rate above 5 percent will have the percentage of the error deducted from their eligibility allocation.

Given the potential liability to an agency for an incorrect eligibility determination, eligibility workers' supervisors must implement an aggressive eligibility file review process. A sample Eligibility File Review Form is included as Appendix I.

B. Advances

Advances can be requested for Patient Care Network contracts only. Advances for Part B contracts are not allowed without special permission from HRSA and only for one month. 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, including the 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.

The first advance request should be dated the same date as the beginning date of the contract. For example, the first PCN advance request should be dated July 1, 2011.

C. 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 executed 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. **All subcontracts must be cost-reimbursement.**
- Lead fiscal agencies must ensure that subcontracts are in compliance with the primary contract and must complete the following forms as part of the subcontracting 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
- Part B and PCN providers are required to report information on subcontractors using the Part B 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 5.

For 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. A contractor or subcontractor must use a formula to calculate the portion of administrative costs associated with direct service categories and 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.

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. Lead agencies must ensure subcontracted agencies comply with the training and monitoring requirements established by the Department and are responsible for disseminating Department medical case management policies, procedures and documents to agencies providing medical case management 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 sustained funding and service delivery. Every full-time equivalent case manager must maintain a minimum caseload of:

- Medical case manager - 60 clients
- Non-medical case manager - 125 clients
- Eligibility specialist - 300 clients

For a case manager supervisor to be funded under either the Medical or Non-Medical Case Management line item, they must also have a case load proportionate to the percentage of funding for the position and/or perform all of the following tasks:

- Hire and fire staff
- Train new staff
- Conduct monthly chart reviews for quality management
- Conduct interdisciplinary team meetings and/or facilitate meetings with partnered providers regarding client-specific issues
- Attend consortia meetings
- Fill in for staff on leave or vacation

Note: Section 3 of this document presents an additional funding source for case management staff under “Section J. 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 are components 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.

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 category is used to fund case management and eligibility staff. Positions under this category are required to have a caseload, must enter client data into CAREWare, and adhere to the requirements of a non-medical case manager as defined in the HIV/AIDS Case Management Operating Guidelines. If medical case managers are also maintaining non-medical case managed clients, their salaries should be proportionally divided between the two service categories. 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 of this guidance for detailed instructions for completing the case management budget narrative.

E. Required Performance Measures

While many organizations throughout Florida have sought to measure the effectiveness and quality of their HIV care delivery, it has not necessarily been a coordinated, aligned process. Consistent assessment of HIV care delivery and measuring desired outcomes is essential for quality measurement and improvement. In order to assess the quality of HIV care with greater uniformity within the state and offer an opportunity for alignment with the nation, Florida will collect data and monitor three of the Group One clinical measures developed by HRSA's HIV/AIDS Bureau.

If an area funds Ambulatory/Outpatient Medical Care and/or Medical Case Management through Part B or PCN, then the bureau will monitor the following three of HRSA's Group One clinical measures:

- Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year
- Percentage of clients with HIV infection who had two or more CD4 T-cell counts performed in the measurement year
- Percentage of clients with AIDS who are prescribed HAART

The reporting requirements and monitoring will vary depending on whether an area utilizes CAREWare for clinical data collection or not.

For areas using CAREWare to capture clinical information:

- The bureau will assume responsibility for running the numbers each month for the required performance measures
- No data submission is necessary
- Validation of numbers is not a required component for lead agencies to monitor subcontracts or contract managers to monitor lead agency contracts

For areas using CAREWare for eligibility **ONLY**:

- Lead agencies are responsible for capturing data for the required performance measures according to HRSA's definitions of the numerator, denominator and patient exclusions found on the detail sheets, which is included as Appendix D
- Lead agencies are required to submit data monthly. A Performance Measure Submission Form recording the numerator, denominator and percentage meeting each measure is due the 20th of every month, beginning in May 2011.
- The Performance Measure Submission Form used to capture the data each month is included as Appendix E. (An Excel version of the form is available upon request.) This form should be sent by the monthly due date via email to Naima Farah in the Reporting Unit of the bureau (Naima.Farah@doh.state.fl.us).
- Lead agencies will randomly pull client files during all monitoring of subcontracted entities that provide Ambulatory/Outpatient Medical Care and/or Medical Case Management services. The lead agency will review files for 10 percent of the average number of clients included in the denominator of each performance measure (at least 10 files, but no more than 50 files). The lead agency will record the numerator, denominator and percentage meeting each performance measure for each of the subcontracted providers.
- Contract managers are responsible for monitoring the numbers collected by the lead agency for each of the subcontracted providers. The numerators and denominators of the subcontracted providers should be added together to arrive at an overall percentage meeting each measure. If this number is plus/minus 20 percent of the average number submitted on a monthly basis by the lead agency for any of the three measures, then the contract manager will develop a Corrective Action Plan.

The bureau will add additional measures in subsequent contract years. For the 2012-2013 contract year, the bureau expects, at a minimum, to include measures related to eligibility and case management care plans.

F. Fee for Service

In accordance with Part B 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 F for details.