SECTION 3: CONTRACT BUDGET

A. Budget

This section provides information regarding the development of the program budget and budget narrative. The service priorities specified in the Local Comprehensive Plan should be available and referred to during the development of the Part B and PCN contract budgets.

Ryan White Part B and General Revenue Network funds for Florida's HIV care consortia programs can be used for the following purposes (in conjunction with the HIV care consortia comprehensive plan) and should address these areas of responsibilities:

- To provide comprehensive outpatient, essential health and support services for individuals and families infected or affected by HIV infection and for services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities.
- To provide health and support services to women, infants, children and youth with HIV, including treatment measures to prevent the perinatal transmission of HIV.
- To meet the special needs of families with HIV, including family centered and youth-centered care.
- To coordinate and expand existing services and to identify service gaps.

B. Budget Categories

Budget categories contained in Attachment 3 (Attachment 1 for county health departments serving as lead agencies) of the contract are explained in this section. There are four potential sections for the provider to consider when developing a budget:

A. Administrative (maximum 10 percent of total award)
B. Direct Care
C. Clinical Quality Management (maximum 5 percent of total award)
D. Percentage of Funds for Women, Infants, Children and Youth (Part B only)

Proposed service categories should be consistent with service priority recommendations in the consortium's comprehensive plan or a written explanation should be provided as an attachment to the contract.

C. Allowable Funded Services

1. HRSA's HIV-Related Service Categories

The most current Ryan White HIV/AIDS Treatment Modernization Act of 2006 Definitions for Eligible Services (see Appendix E) is prepared by HRSA and describes allowable Part B services. Please refer to this information and the HRSA Program Policy Notices during contract development and negotiation. The HIV/AIDS Bureau website link for HRSA program policy notices is http://hab.hrsa.gov/law.htm.

2. General Revenue Patient Care Network

PCNs may fund the following additional line items:

- Row o. Pediatric developmental assessment and early intervention services - The provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. They include comprehensive assessment, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients and education/assistance to schools should also be reported in this category.

- Row ae. Buddy companion services - An activity provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

- Row af. Hospital service - Services provided by a hospital for the medical care on an inpatient under the direction of a licensed physician or dentist. Services may include room and board, medical supplies, diagnostic and therapeutic services, nursing care, supplies and equipment for appropriate care.

- Row ag. Residential care - Therapeutic, nursing, and/or supportive services provided by licensed or certified health care professionals in a licensed residential care facility. Services must be medically prescribed or in accordance with a written care plan established by a case management team that includes appropriate health care professionals.

- Row ah. Nursing home care - Full time nursing and rehabilitative services in a facility licensed by the Agency for Health Care Administration. Care and services must be ordered by and carried out under the direction of a licensed physician.

D. Core and Support Service Categories

HRSA defines core medical services as a set of essential, direct health care services provided to persons living with HIV/AIDS and specified in the Ryan White HIV/AIDS Treatment Modernization Act of 2006. Support services are a set of services needed to achieve medical outcomes that affect the HIV-related clinical status of the person living with HIV/AIDS.

The Florida Comprehensive Planning Network has identified 13 categories as core services in the Statewide Coordinated Statement of Need for 2009-2012:

- Ambulatory/Outpatient Medical Care
- AIDS Pharmaceutical Assistance (ADAP)
- AIDS Pharmaceutical Assistance (local)
- Oral Health Care
- Early Intervention Services
- Health Insurance Premium and Cost Sharing Assistance
- Home Health Care

- Home and Community-Based Health Services
- Hospice Services
- Mental Health Services
- Medical Nutrition Therapy
- Medical Case Management Services (including treatment adherence)
- Substance Abuse Services Outpatient

E. Health Insurance

Health insurance can supplement the need for adequate health care coverage and increase an overall savings to the state. In an effort to prevent the loss of existing health insurance benefits for all clients and prospective clients who have been determined eligible for HIV/AIDS patient care resources programs, funds must be targeted towards individuals who:

- Have a private health insurance policy, but need assistance in maintaining their premiums, deductibles and/or co-pays; or
- Have a private health insurance policy, but do not qualify for enrollment in the AIDS Insurance Continuation Program (AICP).

The amount funded must reflect the current and projected needs of this service for the consortium geographical area taking the following into account:

- Last contract year's health insurance line item allocation
- Last contract year's amount utilized
- Number of clients served
- Coordination with the other funding sources to address this issue (including AICP)
- Increased demand for this service

F. Subcontract Budgets

All subcontracts must be prepared using the same budget guidelines. During the contract review process, the allocations for administrative costs, direct care costs and clinical quality management will be compared with the prior year's allocation for significant increases, decreases or eliminations. For Part B only, the estimated percentage of funds to be spent on the populations of women, infants, children and youth must be entered in Section D of the Budget Summary FY 2010-11, Attachment 3 (Attachment 1 of the Schedule C requirements), of the contract and subcontracts, to comply with HRSA requirements.

G. Section A: Administrative Costs Budget

1. Narrative

The Administrative Costs total is limited to 10 percent of the total award and must be justified in the budget narrative. Administrative costs are reimbursed as fixed price as described under method of payment in Part B of the contract. Expenses must be tracked and available for review by the contract manager or approved staff at any time. All unexpended funds must be returned to the department.

The administrative costs line items within the budget may be shifted during the contract period. However, the total dollar amount of the administrative costs cannot be increased. The contract manager

and area HIV/AIDS Program Coordinator must have prior notification and sign off for this change. An updated budget narrative must be completed for the contract file.

2. Positions

The budget narrative section must include specific reference information when requesting funding for positions and must be in the following order:

- Position title
- Job responsibilities as related to the funded work
- New or existing position
- Justification for the position
- Total annual salary
- Funding amount and percentage of total position funding
- Other funding sources, including amount and percentage of total, if position is partially funded by the contract.

The information above is required on all funded positions regardless of the category and especially applies to case management and other line items funding positions, which must be defined by proposed full time equivalent (FTE). Existing positions and salaries will be compared to prior year's contract.

3. Fringe Benefits

The following fringe benefits must be included in the budget narrative:

- Federal Insurance Contributions Act (FICA): Include the 7.65 percent Social Security tax that is paid by the employer as a match to the amount paid by the employee.
- Life/Disability Insurance: List the amount paid by the employer for insurance for the employee.
- Retirement: List the percentage of the employee's salary as the amount that will be paid by the employer.
- Other: List any benefits for the employee paid by the employer.

4. Staffing

If vacant for more than two weeks, staff positions funded by Part B or PCN must be reported in writing to the department contract manager.

5. Travel

All travel must directly benefit work supported by the funded program. All travel anticipated during the contract period must be listed and specific about who will travel, where, when, how and why the travel is necessary.

General travel requires a department travel voucher for Reimbursement of Traveling Expenses, Form C-676, must be submitted with original receipts for expenses incurred during officially authorized travel and includes items such as car rental, air transportation, parking, meals, lodging, tolls and fares.

6. Office Expenses

Provide a general description of the type of items classified as supplies. Computer software should be included in this category. A description of all other operating expenses must be clearly presented. Expenses in this category will be compared with the prior contract year's expenses and justification for increases and decreases greater than 10 percent of the prior contract year amount must be provided. Other operating expenses must include the same type of justification as required for positions.

7. Equipment

List specific equipment to be purchased and justify the need to purchase the equipment. A purchase versus lease cost analysis should be done for large dollar items. Cost sharing must be applied when equipment will be used for activities other than those associated with Part B or PCN.

H. Section B: Direct Care Costs

All direct care costs are reimbursed as cost reimbursement as described under method of payment in Part B of the contract. All unexpended funds must be returned to the department.

In Attachment 3 (Attachment 1 for county health departments serving as lead agencies), for the column labeled FY 2010-2011 Original Allocation, enter the amount for FY 2010-11 for each service line item funded.

Refer to the most current Ryan White HIV/AIDS Treatment Modernization Act of 2006 Definitions for Eligible Services (Appendix E) for additional information about direct care services.

Funded service category must include:

- **Service Category**: Name the service
- **Explanation:** Justification for the service category, which should include:
  - How the results of the local needs assessment relates to the proposed service category;
  - Where the service ranked in the prioritization process; and
  - How and why the service is or is not consistent with the Statewide Coordinated Statement of Need. Justify any direct care cost that exceeds the Medicaid rate and provide an explanation for significant increases and decreases (greater than 10 percent) or elimination of funded direct care categories as compared to last year's contract allocation. (Medicaid provider fees schedules can be found at http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabId/44/Default.aspx.)
- **Service Delivery Process:** The delivery process should be described briefly for each service category funded by Part B or PCN including information about provider selection. Include information such as units of service, number of visits, authorization protocol, service limitations, caps and exceptions.
- **Allocation Methodology:** Include information such as basis for expenditure, review process and needs assessment ranking.
- **Additional Guidelines:** Include description of guiding principles developed by consortium and other related policies or guidelines.
- **Provider Information:** Include the following information for each contracted provider:
  - Name and address of provider
  - Method of Payment
  - Funding Amount

- Number of clients to be served by agency
- Number of staff in FTEs, if service category allows funding of FTEs.
- Additional narrative if necessary

1. Expenses Not Allowed

Examples of expenses not allowed for Ryan White Part B and Patient Care Network services include, but are not limited to, clothing, financial loans or gifts, medical care unrelated to HIV/AIDS and social services unrelated to HIV/AIDS. Billing for food that does not fall under direct care budget line item such as delivered meals, food vouchers or food bank is also prohibited. Refer to the HAB Program Policies at http://hab.hrsa.gov/law.htm for additional information.

2. Budget Narrative for Case Management Services

The following provides instructions for the medical case management and the case management (non-medical) budget narrative.

Service Category: Medical Case Management Services

- **Amount**: List the total allocation for medical case management services.
- **Explanation**: Use the following condensed explanation:

  Medical case management services are a range of client-centered services that link clients with health care, psychosocial and other services to ensure eligibility determination, timely, coordinated access to medically appropriate levels of health and support services, continuity of care and ongoing assessment of the client consistent with the 2008 Glossary of Services definitions, the *Florida HIV/AIDS Case Management Operating Guidelines* and the Florida Department of Health *Eligibility Procedure's Manual*.

  Also include service information specific to the provider.
- **Service Delivery Process**: The delivery process should be described briefly including information about provider selection. Include information such as units of service, number of visits, authorization protocol, service limitations, caps and exceptions.
- **Allocation Methodology**: Include information such as basis for expenditure, review process and needs assessment ranking.
- **Additional Guidelines**: Include description of guiding principles developed by consortium and other related policies or guidelines.
- **Provider Information**: Include the following information for each contracted provider:
  - Name and address of provider
  - Method of Payment
  - Funding Amount
  - Number of clients to be served by agency
  - Number of medical case managers in FTEs
  - Number of supervisors in FTEs
  - Number of other case management personnel in FTEs
  - Additional narrative if necessary

All staff funded under Part B or PCN must be accounted for in FTEs. Cost reimbursement contracts must not require case managers to document each 15-minute increment of medical case management services for accountability or reporting (AIMS).

This budget information for the contract may be lengthy depending on the number of agencies providing medical case management services and can be included as an attachment to the contract or incorporated directly into the format. Information to include:

- Fiscal breakdown for the number of case managers
- Supervisors and other case management personnel
- Fringe
- Travel expenses
- Office expenses
- Equipment
- Other costs will be specified in the agency sub-contract budget

Service Category: Case Management (Non-Medical)

- **Amount**: List the total allocation for case management (non-medical) services.
- **Explanation**: Explain the services to be provided for this service and the target population.
- **Service Delivery Process**: The delivery process should be described briefly including information about provider selection. Include information such as units of service, number of visits, authorization protocol, service limitations, caps and exceptions.
- **Allocation Methodology**: Include information such as basis for expenditure, review process and needs assessment ranking.
- **Additional Guidelines**: Include description of guiding principles developed by consortium and other related policies or guidelines.
- **Provider Information**: Include the following information for each contracted provider:
  - Name and address of provider
  - Method of payment
  - Funding amount
  - Number of clients to be served by agency
  - Number of case managers (non- medical) in FTEs
  - Number of supervisors in FTEs
  - Number of other case management personnel in FTEs
  - Additional narrative if necessary

All staff funded under Part B or PCN must be accounted for in FTEs. Cost reimbursement contracts must not require case managers to document each 15-minute increment of medical case management services for accountability or reporting (AIMS).

This is a flexible funding category and can be used to fund case management, eligibility, support staff or other staff with specific expertise to provide the assistance and advice described in this case management (non-medical) category.

I. Section C: Clinical Quality Management Budget

It is recommended that clinical quality management (CQM) be reimbursed as cost-reimbursement; however, CQM can be fixed-price as described under method of payment in Part B of the contract. A maximum of 5 percent of the contract amount may be allocated to planning and evaluation activities. A narrative description for each category funded must be provided. As with Administrative Costs, any positions funded under this category must include specific reference information when requesting funding for positions and must be in the following order:

- Position title

- Job responsibilities as related to the funded work
- New or existing position
- Justification for the position
- Total annual salary
- Funding amount and percentage of total position funding
- Other funding sources, including amount and percentage of total, if position is partially funded by the contract

The narrative must specify any activities funded under "Other program support - state priorities."

Planning and development may include travel for two additional attendees to the Patient Care Planning Group (PCPG) meeting. Additional attendees should be Ryan White grantee partners or selected planning body members considered essential to the PCPG effort.

J. Section D: Percentage of Funds for Women, Infants, Children and Youth

Percentage of funding for Women, Infants, Children and Youth (WICY) is reported in Section D of the Ryan White Part B contracts only. The percentage is to be calculated from the direct care service budget amounts only; do not include administrative or program planning and support budget amounts.

HRSA requires the state to determine the percentage of funds used for each of the WICY populations. For each population category, the percentage of funds allocated must be equal to or greater than the percentage of AIDS cases reported in that category. For example, if the percentage of AIDS cases for infected infants in an area is 1 percent, then the percentage of funds allocated to the service in the area must be 1 percent or more. HRSA defines WICY as follows:

Group	Age	Sex
Infants	Under 2-years old	All
Children	Ages 2-12	All
Youth	Ages 13-24	All
Women	Ages 25 and older	Women

Each consortium/lead agency must document WICY expenditures and report related data in the required format. See the *Reporting Requirements for Programs Funded by the Ryan White HIV/AIDS Treatment Modernization Act, Part B*, revised for 2010-11, for data requirements and formats. WICY data is due on May 1 following the previous April-March service year.

K. Budget Revisions

Budget revisions to patient care contracts do not require a contract amendment. However, the providers must report all budget revisions using the contract Attachment 3 (Attachment 1 for county health departments serving as lead agencies) and complete the columns labeled FY 2010-2011 Increase/Decrease and FY 2010-2011-Revised Allocation. In addition, the provider must submit a narrative justifying the reason for the increase or decrease. The Department of Health contract manager will approve and sign the revised budget and justification narrative. If funds are being moved from a core service to a support service, the contract manager must send the budget revision to the Community Programs Coordinator for review prior to approval. If funds are being moved from one core service to

another or from a support service to a core service, Community Programs review prior to approval is not required.

Revisions that will increase/decrease Direct Services categories may be requested. Requests may also be made to move unexpended funds from the Administrative and Clinical Quality Management categories into the Direct Services category only and may not be used to increase Administrative or Clinical Quality Management costs.

Once a revision is reviewed and approved, the contract manager will place the revised contract Attachment 3 (Attachment 1 for county health departments serving as lead agencies) and the justification narrative in the contract file and on the shared drive and send a copy to the following entities by email:

- Disbursements (individual analyst)
- Reporting and Information Systems Unit via AIMS
- Community Programs Coordinator