

Administrative Guidelines FY 2014-15 Questions & Answers

Section 1

None covered on the webinar.

Section 2

1.Question: Who is responsible if a client is erroneously determined eligible?

Answer: The organization determining eligibility is responsible.

2.Questions: Has the 125 minimum for non-medical Case Managers been eliminated? No mention is made of Eligibility Specialists, which were at a caseload of 300 clients monthly, at minimum.

The minimum caseload for every FTE case manager being 60 clients is new. Why the change?

Answer: This change is not new. As of June 2013, medical and non-medical case management were combined for a continuous minimum caseload requirement of 60 clients per FTE per month. As eligibility is considered a non-medical case management service, no separate eligibility remedy was stated in the revised 2013-14 guidelines. This change was added to the 2013-14 Administrative Guidelines during the last revision. A remedy was developed for this requirement and was included in the last round of contract amendments for 2013-14.

3.Question: The Administrative Guidelines state that the salaries of medical case managers, who also maintain non-medical case managed clients, should be proportionally divided between the two service categories, and that eligibility determination is defined as a support service under Case Management (non-medical) and is not considered to be an administrative cost. Please explain. Does this affect the caseload requirement?

Answer: No. The caseload requirement for medical and non-medical case managers is still a minimum of 60 clients per FTE case manager, per month. If a medical case manager has a caseload of clients that are both medical and non-medical, dividing their salary proportionally means listing the corresponding FTE percentage and portion of their salary under the Medical Case Management line on the budget, and listing the corresponding FTE percentage and remaining portion of salary under the Case Management (Non-medical) line. Example: Agency ABCD funds one full-time case manager at a salary of \$40,000. This case manager spends 75 percent of their time on medical case management and 25 percent on non-medical case management. In this example, the budget summary should list \$30,000 under Medical Case Management and \$10,000 under Case Management (Non-medical) to reflect the appropriate proportion of the case manager's duties/activities. The budget narrative should match these totals, as well as list .75 FTE under Medical Case Management and .25 FTE under Case Management (non-medical), to total 1 FTE.

4.Question: Why were HRSA's Core Clinical Measures taken out?

Answer: By changing the requirement to relate to minimum data elements in CAREWare, the HIV/AIDS and Hepatitis Section will be able to respond to future requests from HRSA related to the clinical measures, even if revised.

5.Question: Under Fee for Service, why was the reference to Section B of Attachment I removed, and why was the language changed to state that fees shall be assessed when “applicable” instead of when “practical”?

Answer: The reference to Section B in Attachment I was removed to reflect updated language. The term “applicable” is relevant to area sliding fee policy.

6.Question: (Section 2, Page 4, I. Vital Status) Can providers bill for services after a client is deceased or when closing a client file due to death if services were delivered in the weeks prior to death?

Answer: Providers may bill for services which were provided and entered into CAREWare prior to a client’s death.* This instruction in the Administrative Guidelines is meant to explain that there should be no services showing a service date that comes *after* the deceased date that has been entered into CAREWare. Additionally, the actual closing of the client’s status due to death should not be posted as a medical or non-medical service on the Services tab. All services provided should be entered in a timely fashion. If services were provided to a client prior to the client’s death that service data should already have been entered into CAREWare, thereby preventing the need to enter the services after the time of their death. However, even if an agency finds out long after the fact that a client has passed away, CAREWare allows for services provided before the death to be entered, using the previous date of service.

*This sentence was slightly changed to clarify the issue of billing. The remaining text is the same language used on the Administrative Guidelines Webinar to explain data entry of services for deceased clients.

Section 3

1.Question: What is covered under administration?

Answer: Some examples of administrative costs include utilities, rent, salaries for administrative positions, fringe, benefits, and travel directly benefitting work supported by the funded program.

2. Does the provider’s 10 percent for administration affect the lead agency’s overall 10 percent administration cost?

Answer: No, not at this time.

Question: What is covered under direct care cost vs. the admin cost?

Answer: Please refer to the Budget Summary (Attachment IV for contracted providers) for direct and support services. For administration, please refer to examples previously provided. For the full descriptions of direct care services (core and support), go to Appendix E: Ryan White Program Definitions of Eligibility Services.

3.Question: Why do these new guidelines fail to address the office supplies issue when this has been a problem area for so many agencies throughout the state?

Answer: This issue is addressed in Attachment I under Unallowable Costs.

4.Question: Why is there no calculation for taking the office supply issue into account?

Answer: Refer to RFP DOH11-053, Section 4.19 Equipment, which states: The successful respondent(s) will be responsible for supplying at their own expense, all equipment necessary to perform under the contract, including but not limited to computers, telephones, copiers, fax machines, maintenance and office supplies.

5. **Question:** Can communications expenses include telephone/internet services and be billed as a line item under Direct Care?

Answer: These expenses are allowable but must be included as part of the 10 percent administration.

6. **Question:** In situations where an employee is only a partial FTE and travel reimbursement is submitted, should the travel ever be the same percentage as the FTE or should it always be 100 percent? Example: An employee is 50 percent or 0.5 FTE. Should the travel only be reimbursed 50 percent or should it be 100 percent?

Answer: The reimbursement should be 100 percent if the travel event is related 100 percent to the work performed. Travel is not pro-rated by proportion of FTE.

7. **Question:** What are examples of expenses that are not allowed?

Answer: See the Administrative Guidelines, Section 3, page 3, g. Expenses Not Allowed.

8. **Question:** The Administrative Guidelines state that “contracts must not require case managers to document each 15-minute increment of medical case management services for accountability or reporting.” Is this not an allowable practice or is this just a recommendation?

Answer: This is a recommendation.

10. **Question:** What are the differences between Core and Support Services Categories? **Answer:** See the Administrative Guidelines, Section 3, C. Core and Support Service Categories. Core and support service categories are defined by HRSA. See Appendix E: Ryan White Program Definitions of Eligible Services.

11. **Question:** If services do not fall under Core Medical Services or Support Services, will they be reimbursed out of Administration?

Answer: No client services are reimbursed out of administration.

12. **Question:** Is there any restriction on moving funds from line item to line item, except for the restriction on moving funds from direct care to administration?

Answer: See Section 3, F. Budget Revisions. For example, any budget revisions requested within the last 30 days of the contract must be approved, in writing, by the Bureau of Communicable Diseases, Contract Unit.

13. **Question:** When reviewing the quarterly financial report with back-up documentation, are contract managers only required to check back-up once?

Answer: This is the minimum requirement. However, it is a good quality management practice to review the QFR and back-up documentation on a more consistent basis and always during contract monitoring.

Section 4

1. **Question:** Who makes the determination as to whether additional monitoring will be conducted? What are the guidelines and criteria for deciding what additional monitoring is to be done?

Answer: Ultimately, the contract manager represents the Department in the relationship with the provider and all requests for additional monitoring should start with the contract manager. Additional monitoring may result from a whistleblower, a corrective action plan, or a change in monitoring requirement from the Feds or the Department of Health. Even the processing of a monthly invoice could prompt a need to return for further analysis.

Section 5

1. **Question:** Monthly invoices for Part B and PCN contracts are not to be processed for payment unless all reporting requirements have been met for the month. Does this refer only to reporting by the provider to the Lead Agency or also to the Lead Agency's reporting requirements?

Answer: Both the provider and lead agency are responsible for meeting the reporting requirements. All lead agencies and subcontractors must comply with contract requirements. If reporting requirements are included as deliverables in the contract, they must be submitted according to those contract provisions, or financial consequences will apply. Processing of monthly invoices could be delayed if all reporting requirements have not been met.

2. **Question:** Is the Monthly Demographic Report considered the same as the FTTY Report, which goes in each month with the invoices?

Answer: This report should have been listed as the FTTY (First Time This Year) Report. It has been corrected in the guidelines.

3. **Question:** Under Report Submission, the charts for Ryan White Part B Consortia and Emerging Communities, County Health Department General Revenue Funding, and Patient Care Networks General Revenue Funding list "TBA" and "Word Document" in the columns next to Implementation Plan and Revised Implementation Plan. What does this mean?

Answer: "TBA" means that the due date for these plans is "to be announced" at whatever point the Patient Care Program has been notified of the official due date from HRSA. The reference to the Word Document is to note that these plans are submitted using the Word Document form sent out by the Reporting Unit, as they are not currently submitted through AIMS 2.0.

4. **Question:** Regarding "TBA" for Implementation Plan and Revised Implementation Plan, what are the planned dates?

Answer: Submission deadlines for these plans are set by HRSA and tend to vary from year to year. TBA was previously designated due to the variability. In all but one of the charts, the term TBA has been changed to "varies by year" to better explain the absence of a specific date. For these reports the Reporting Unit will send notification to the field via e-mail when an official due date has been established. Please note that "TBA" is still used in the chart listing due dates for the ADAP related reports.

5.Question: What is the Provider/Sub-contractor Report? Is this the Minority Business Enterprise (MBE) Report?

Answer: The Provider/Sub-contractor Report is one of the mandated federal reports the Patient Care Program submits annually to HRSA. It is not the same as the MBE Report, which is no longer required and is not in AIMS 2.0. The Provider/Sub-contractor Report in AIMS 2.0 identifies each Ryan White Part B funded contract provider, the contract amount, and the service/activity to be provided under that contract. This summary information helps HRSA monitor and track the use of grant funds for compliance with program and grants policies and requirements.

6.Question: Is there a report in AIMS called Annual Contract Negotiation, or something like a Memo of Negotiations that the provider puts into AIMS after contract negotiations have been completed?

Answer: No. There is no Annual Contract Negotiation report or any other related report in AIMS 2.0. The reference to “Annual Contract Negotiation” under the Patient Care Networks General Revenue Funding chart has been removed, as it is not an actual report submitted to the Community Programs Unit.

Appendix F: Units of Service

1.Question: For outpatient ambulatory care, can a telephone encounter count as a unit of service?

Answer: The unit of service for Ambulatory/Outpatient Medical Care equals 1 visit; the visit may be to a doctor’s office, a health care clinic or other outpatient medical facility.

2.Question: Is it allowable for an agency to charge Part A and Part B for case management services for the same client on the same day?

Answer: No. This would be considered double-billing.

3.Question: Units of services were always based on increments of time and now they are based on encounters. Changing this in the middle of the grant year will significantly impact our data and our providers. How will this be handled?

Answer: When modifying the subcontracts to include Attachment I, revise the tasks to include this data element.

Appendix G: CAREWare Data Entry Requirements

1.Question: On page 2, under Ambulatory/Outpatient Medical Care (AOMC) – entry into Encounters – we currently enter this information into Services. Also, for those clients that receive co-pay assistance, this information is listed under Health Insurance in the Service line item, not AOMC; this information has not been entered into CAREWare except for what is entered into Services. Clarification is needed. Are the directions under AOMC just for clinics?

Answer: Everything is driven by what you input on the Service tab. If you enter an AOMC service on the Service tab for the client, all the corresponding medical information must be inputted such as CD4s, viral loads, screened for syphilis, etc. Entering a Health Insurance

Program service such as copays) does not require the clinical information to be inputted. Every agency that inputs an AOMC service for a client must input the clinical information, not just the clinics.

2.Question: Is the information listed on the page for labs (numbers 1, 3, 4, 5 and 6) being submitted by the Part C's, and if so would it be duplication if the Part B's also enter it? For clients only having a co-payment paid out of Part B funds, we are not receiving all of this required information and it is listed (not broken down) under Health Insurance in the Service section for the visit.

Answer: If you are simply inputting a Health Insurance Program service for a client, no clinical information needs to be entered for that individual. If you input an AOMC service for a client, you must enter the required clinical data into the same domain. Meaning: If a client received an AOMC service at Agency A, the clinical data for that client must be inputted into Agency A's domain. If by chance that same client was also in the Clinic Z domain, and all the needed clinical data was within that domain, clinical data would still need to be inputted into Agency A's domain because CAREWare does not look across domains for data when compiling the RSR files.

Appendix H: Grievance Policy

1.Question: Are clients who are not eligible, and who are complaining about services not being provided, included on the monthly grievance log?

Answer: No, unless the complaint is related to the eligibility determination process.

2.Question: What is the complaint procedure for ineligible or unenrolled clients if they wish to complain or file a grievance? Do they complain to the HAPC?

Answer: The local agency protocol should be followed, unless the complaint is related to the eligibility determination process.

3.Question: What happened to the appeals log (that used to be part of the grievance policy attachment)?

Answer: The monthly grievance log template has been made available on the Patient Care website: http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/_documents/copy-of-grievance-report.xls.