

PATIENT CARE CONTRACT ADMINISTRATIVE GUIDELINES

RYAN WHITE PART B &  
GENERAL REVENUE PATIENT CARE NETWORK  
PROGRAMS

# Administrative Guidelines 2013–2014



# Patient Care Contract Administrative Guidelines FY 2013-2014

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## SECTION 1: INTRODUCTION

The Florida Department of Health (Department), HIV/AIDS and Hepatitis Section, administers a variety of HIV/AIDS patient care programs. Some of these programs include, but are not limited to, the following:

- Ryan White Part B
- Emerging Communities
- Patient Care Networks
- Housing Opportunities for Persons With AIDS (HOPWA)

A brief explanation of each of these programs is found in Appendix A.

A glossary of terms and acronyms used in this guidance is included as Appendix B.

### **A. Purpose of the Guidelines**

These guidelines are written for both contract managers and the lead fiscal agencies. For contract managers, the guidelines describe their roles and responsibilities and provide assistance in developing lead agency contracts and the monitoring of those contracts. For lead fiscal agencies, the guidelines describe their roles and responsibilities, the provisions of the lead agency contract, the requirements of subcontracts and the monitoring of subcontractors.

The guidelines apply to both Ryan White Part B (Part B) and General Revenue Patient Care Network (PCN) contracts.

### **B. Roles and Responsibilities: HIV/AIDS and Hepatitis Section**

The Department is the grantee for Florida's federally funded Part B program. The HIV/AIDS and Hepatitis Section, Patient Care Resources, is responsible for the management of this statewide program. As the grantee, the Department provides funding statewide to Florida's Part B HIV care consortia programs. The Department enters into contracts with lead fiscal agencies to provide services to the HIV-infected community in compliance with Part B program requirements.

Similarly, the HIV/AIDS and Hepatitis Section, Patient Care Resources contracts with lead fiscal agencies to administer PCN programs. There are seven PCNs in Florida. PCNs follow the same guidelines as the Part B programs.

The following represent some of the Department's roles and responsibilities as grantee:

- Ensure the health and well-being of Floridians by providing access to HIV patient care and support services
- Coordinate statewide policy and procedures
- Prepare and submit the statewide Part B grant application to the Health Resources and Services Administration (HRSA)
- Act as fiscal administrator of all Part B and PCN funds

- Ensure compliance with all Part B and PCN requirements
- Ensure Part B and PCN are payers of last resort
- Prepare and review the Part B and PCN contracts
- Ensure match of state funds
- Ensure the Part B care consortia conduct needs assessments, prepare service plans and coordinate service provisions (see G. Ryan White Part B Care Consortia on page 4)
- Respond to all federal and state programmatic and reporting requirements
- Monitor and audit activities of consortia, emerging communities, lead agencies and primary contractors
- Facilitate statewide meetings
- Provide technical assistance

### **C. Roles and Responsibilities: Lead Fiscal Agencies (contracted agencies and County Health Departments)**

The Part B and PCN lead fiscal agencies play an essential role in providing patient care and support services to the HIV/AIDS population. They are responsible for administrative and fiscal reporting and other Part B and PCN-related duties as specified in the contracts.

All lead agencies act as the fiscal agent and data coordinator for the contracted providers within their area. The Department enters into contractual agreements with lead agency organizations that subcontract with other service providers. The roles and responsibilities of lead fiscal agencies include, but are not limited to:

- Sign the primary Part B and PCN contracts with the state
- Develop and execute subcontracts
- Act as fiscal administrator of Part B and PCN funds
- Process invoices from subcontractors
- Reimburse subcontractors
- Submit program and financial reports to the state
- Ensure client satisfaction surveys are conducted and reviewed
- Provide technical assistance to subcontractors
- Monitor subcontractors
- Facilitate the provider selection process
- Develop and ensure emergency procedures in preparation for disasters
- Administer needs assessments as required
- Ensure subcontractors are entering data into CAREWare as required
- Develop with the care consortia the local comprehensive plans (Part B only)
- Develop with the care consortia service delivery guidelines with service caps (see Section 3.C., Core and Support Service Categories)
- Implement a local formulary for medication which may not be available on the ADAP formulary
- Provide administrative support to the consortia and promote consumer involvement (Part B only)
- Support the local planning body in the development of the Comprehensive Plan (Part B only)
- Maintain consortia files (Part B only)
- Ensure training and technical assistance resource materials are available to consortia members (Part B only)
- Organize consortia mailings (Part B only)

## **D. Roles and Responsibilities: County Health Departments as the Lead Fiscal Agencies**

In some areas of the state, the county health department (CHD) serves as the lead fiscal agency. As the lead agency, the CHD assumes administrative, fiscal and other responsibilities for their area. For these CHDs, the Department puts the funding on Schedule C and includes an instruction letter stating the requirements for using the funds. The CHDs prepare and submit Part B and/or PCN budgets using the budget narrative and the budget summary formats provided as part of the contract templates. This budget is subject to programmatic and administrative review. CHDs serving as lead fiscal agencies are subject to the same programmatic and monitoring requirements as other lead agencies. The Community Programs Coordinator for the consortium area serves as the monitor for the Schedule C requirements.

CHDs serving as lead fiscal agencies are required to maintain and submit, upon request, back-up documentation for all expenditures charged to either Part B or PCN as reported in the AIDS Information Management System (AIMS).

## **E. Lead Agency Policies**

According to the enacting legislation and the Code of Federal Regulations (CFR), lead agencies and providers receiving Part B funding should have the following written policies in place. In Florida, these requirements apply to PCNs as well. (See Section 4, "Contract Monitoring.")

- Establish eligibility and clinical policies to ensure that providers do not:
  - Permit denial of services due to pre-existing conditions
  - Permit denial of HIV services due to non-HIV-related conditions (primary care)
  - Provide any other barrier to care due to a person's past or present health condition
- Establish policies and procedures that provide, by referral or vouchers, transportation if facility is not accessible to public transportation
- Code of Ethics or Standards of Conduct
- Bylaws and Board policies
- Personnel policies:
  - Have policies and staff training on the requirement that Part B and PCN are the payers of last resort and how that requirement is met
  - Include in personnel manual and employee orientation information on regulations regarding lobbying with federal funds
  - Have policies that discourage: the hiring of persons with a felony criminal record; the hiring of persons being investigated by Medicare or Medicaid; and large signing bonuses
  - Have adequate policies and procedures to discourage soliciting cash or in-kind payments for: awarding agreements, including contracts; referring clients; purchasing goods or services; and/or submitting fraudulent billings
  - Policies that discourage the use of two charge masters, one for self-pay clients and a higher one for insurance companies
  - Purchasing policies that discourage kickbacks and referral bonuses per HRSA Universal monitoring standards
  - Have a Conflict of Interest policy
- Develop fiscal, programmatic and general policies and procedures that include compliance with federal, Part B and PCN fiscal and programmatic requirements

- Develop and consistently implement policies and procedures that establish uniform administrative requirements governing the monitoring of agreements, including actions to be taken when corrective action plan issues are not resolved in a timely manner
- Have in place policies that forbid the use of Part B and PCN funds for cash payments to service recipients
- Establish and consistently implement billing and collection, purchasing and procurement and accounts payable and accounting policies and procedures
- Establish policies and procedures that acknowledge the revisionary interest of the federal government over property improved or purchased with federal dollars
- Have in place policies and procedures to determine allowable and reasonable costs
- Have in place financial policies and procedures that guide selection of an auditor
- Establish policies and procedures for handling Part B and PCN revenues including program income
- Have in place policies and procedures that allow the grantee as funding agency prompt and full access to financial, program and management records and documents as needed for program and fiscal monitoring and oversight

### **DOH Required Policy**

All providers receiving either Part B or PCN funding must have a written, board approved policy relating to public access to records that are exempt. The policy should address the types of records which must be produced or are to be made, charges for copying documents, time-frames for providing documentation, or procedures for denying access to documentation. This policy is in accordance with the Department's Standard Contract.

### **F. Conflict of Interest**

The lead agency must be particularly cognizant of the potential for conflicts of interest or the perception of such conflicts as they operate in their respective geographical areas. The Department requires the lead fiscal agency to establish and implement procedures to avoid conflicts of interest in the procurement and contract management process as well as the planning processes of the consortium.

### **G. Ryan White Part B Care Consortia**

According to HRSA, a Part B care consortium is:

“an association of one or more public, and one or more nonprofit private, (or private for-profit providers or organizations if such entities are the only available providers of quality HIV care in the area) health care and support service providers and community-based organizations...”

Consortia act in an advisory capacity to the state for the purpose of planning and prioritizing the use of Part B funds; provide a forum for the infected individuals and affected communities, providers and others; and facilitate the provision of coordinated, comprehensive health and support services to people infected and affected by HIV/AIDS. A consortium must include people living with HIV/AIDS.

The responsibilities of HIV care consortia generally fall under the following categories:

- Priority Setting
- Comprehensive Planning

- Coordination
- Service Delivery
- Capacity Development

The responsibilities of the consortia include, but are not limited to:

- Participation in the needs assessment process
- Development and recruitment of members to ensure an effective planning body
- Development of service priority funding recommendations
- Participation in the development of the comprehensive plan
- Promotion of the coordination and integration of community resources
- Evaluation of the effectiveness of the consortium

## **H. Payer of Last Resort**

Funds may not be used to provide items or services that have already been paid, or can reasonably be expected to be paid, by third party payers, including Medicaid, Medicare, other state or local entitlement programs, prepaid health plans or private insurance. It is therefore incumbent upon providers to ensure that eligible individuals are expeditiously enrolled in Medicaid and that Part B funds are not used to pay for any Medicaid-covered services for Medicaid enrollees. It is also important to ensure that providers pursue Medicaid and other third party payment when covered services are provided to beneficiaries of other programs. For example, if an applicant is eligible for Medicaid, the provider should retroactively bill Medicaid for Part B services provided during the time that eligibility was being determined.

In areas where other HIV/AIDS funding is available, such as PCN and HOPWA, Part B does not require that each of these funding sources be exhausted prior to accessing Part B. Payment for eligible services should be coordinated across these funding streams. Technical assistance regarding payer of last resort issues is available from each area's contract manager and HIV/AIDS Program Coordinator.

## **I. Program References**

Listed below are Internet links to resource materials:

- HIV/AIDS and Hepatitis Section (State of Florida): [http://www.doh.state.fl.us/disease\\_ctrl/aids/index.html](http://www.doh.state.fl.us/disease_ctrl/aids/index.html)
- HIV/AIDS Bureau (Federal): <http://hab.hrsa.gov/>
- HRSA Program Policy Notices: <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>
- HRSA Monitoring Standards: <http://hab.hrsa.gov/manageyourgrant/granteebasics.html>
- Ryan White HIV/AIDS Treatment Extension Act of 2009: <http://www.gpo.gov/fdsys/pkg/PLAW-111publ87/html/PLAW-111publ87.htm>
- Ryan White Programs (i.e. Parts A, B, C, etc.): <http://hab.hrsa.gov/abouthab/aboutprogram.html>
- Federal Ryan White Reporting Requirements: <http://hab.hrsa.gov/manageyourgrant/reportingrequirements.html>
- HIV/AIDS and Hepatitis Policy Notices: [http://www.doh.state.fl.us/Disease\\_ctrl/aids/care/Program\\_notices.html](http://www.doh.state.fl.us/Disease_ctrl/aids/care/Program_notices.html)
- Florida Administrative Code 64D-4 <https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64D-4>

Please direct questions regarding the programmatic development of the Part B or PCN contract to your local contract manager. See Appendix K of this guidance for HIV/AIDS and Hepatitis Section and Reporting Section staff contact information.

## SECTION 2. CONTRACT PROCEDURES AND RESTRICTIONS

### A. Eligibility for Services

All clients receiving services from Part B, PCN, or other programs administered by the HIV/AIDS and Hepatitis Section, must be determined eligible based on [Chapter 64D-4](#), Florida Administrative Code. All contracted providers that determine core eligibility are required to enter eligibility information on every client into the eligibility module in the state CAREWare system. See Appendix I, CAREWare Data Entry Requirements for instructions.

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.

### B. Advances

A one-time advance is permissible for PCN and Ryan White contracts. Contact your local contract manager to access the Finance and Accounting Financial Memo 12-03:

([http://dohiws/Divisions/administration/Fin\\_Acct/Financial\\_Memorandums/FM11-12/FM12-03.pdf](http://dohiws/Divisions/administration/Fin_Acct/Financial_Memorandums/FM11-12/FM12-03.pdf)).

### C. Remedies

Failure to provide the required deliverables per the terms of the contract shall result in a financial consequence. The total penalty amount will be deducted from administrative, direct care, and/or Clinical Quality Management (CQM) costs submitted on the monthly invoice. The following deliverables apply to all Part B and PCN contracts (unless otherwise specified in individual contract), and related subcontracts. Additional CQM deliverables, specific to each entity receiving Part B and PCN funding, are included in the Attachment I of each individual contract.

<i>Administration (Monthly)</i>				
Description	Output	Parameters	Explanation of output	Financial Consequence
Data reporting within the AIDS Information Management System (AIMS)	FTTY Data	Submit monthly by 20 <sup>th</sup> of the month following the month of report. Reports due on a state holiday or a weekend date must be submitted on the next business day.	(FTTY) First Time This Year. The provider collects data on all unduplicated clients served per month within the contracted year. Data are compiled by the HIV/AIDS and Hepatitis Program and submitted to HRSA to meet the grantee requirements.	The amount of the invoice will be reduced by \$100 per business day after report is late or delinquent. Total will be deducted from administrative costs submitted on monthly invoice.

*Administration (Monthly)*

<b>Description</b>	<b>Output</b>	<b>Parameters</b>	<b>Explanation of output</b>	<b>Financial Consequence</b>
Expenditure Reporting Form	Expenditure Reporting Form	Submit monthly by 20 <sup>th</sup> of the month following the month of report. Reports due on a state holiday or a weekend date must be submitted on the next business day.	Expenditure report data must be extracted from the CAREWare database to report units of service, unduplicated clients served and cost. The Expenditure Reporting Form must be entered in AIMS, printed, and submitted to contract manager with invoice back up material.	The amount of the invoice will be reduced by \$100 per business day after invoice is late or delinquent. Total will be deducted from administrative costs submitted on monthly invoice.
Invoice Submittal	Monthly Invoicing	Process client service bills within 30 calendar days of receipt.	Lead agency will process client service bills within 30 calendar days of receipt.	The amount of the invoice will be reduced by \$25.00 per invoice not processed within 30 calendar days of receipt. Total will be deducted from administrative costs submitted on monthly invoice.

*Direct Care (Monthly)*

<b>Description</b>	<b>Output</b>	<b>Parameters</b>	<b>Explanation of output</b>	<b>Financial Consequence</b>
Medical/Non-Medical Case Management Caseload Size	Minimum Caseload	Minimum Caseload per FTE	Each case manager must maintain a monthly minimum caseload of 60 clients per 1.0 FTE.	\$100 per client below 60 for each 1.0 FTE case manager.

*CQM (Annually)*

<b>Description</b>	<b>Output</b>	<b>Parameters</b>	<b>Explanation of output</b>	<b>Financial Consequence</b>
Consortia Coordination	Meeting Schedule	Provide draft of scheduled meeting dates by 30 days after execution of contract. If schedule is due on a state holiday or a weekend date, it must be submitted on the next business day.	Schedule of meeting dates must be made available to contract manager to verify deliverable is met.	\$100 per business day after schedule is late or delinquent. Total will be deducted from administrative costs submitted on monthly invoice.
Consortia Coordination	Meeting minutes	Provide draft minutes of the local consortia meeting(s) to contract manager within 20 days of the meeting. If draft minutes are due on a state holiday or a weekend date, they must be submitted on the next business day.	Meeting minutes must be made available to contract manager to verify deliverable is met.	\$100 per business day after minutes are late or delinquent. Total will be deducted from administrative costs submitted on monthly invoice.

## **D. Subcontractors**

The provider may subcontract for services under their contract and must adhere to the following guidelines:

- All subcontracts will be written consistent with the beginning and end dates of the Part B or PCN lead agency contract.
- 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
  - Financial and Compliance Audit
  - Civil Rights Checklist
  - Conflict of Interest
  - Certificate Regarding Debarment and Suspension
  - Federal Sub Recipient and Vendor Determination Checklist
  - IRS form W-9
  - Ryan White Comprehensive AIDS Resources Emergency Act Contracts/Subcontracts Review Certification
  - Scrutinized Company Certification (if applicable)
- Subcontracts must be reviewed by the Department contract manager and lead fiscal agencies must receive prior approval from the contract manager before subcontracts are executed. Lead fiscal agencies are required to provide the contract manager with electronic copies of all subcontracts written for Part B and PCN funds. The contract manager will post the subcontract, budget summary, and budget narrative on the Department's contract share drive.
- 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 AIMS, consistent with the reporting requirements in Section 5.
- All county health departments and affiliates such as Health Planning Councils and Universities acting as lead fiscal agencies are required to competitively procure medical case management and non-medical case management services. This process is based on 287.012 (1), Florida Statutes.

As a best practice, all other lead agencies are encouraged to conduct competitive procurement for case management services if they are not provided in-house.

### **E. Indirect Costs**

For Part B and PCN contracts and subcontracts, the allocation of indirect costs to services category line items is not allowable.

The medical case management and case management (non-medical) line items will only pay salaries, fringe (FICA) and benefits. Indirect costs, which include but are not limited to rent, utilities and supplies, will **NOT** be funded in service line items. These costs must be included in the administrative costs. It is allowable to allocate up to 10 percent of the total contract amount to administrative costs when necessary to administer the contracted program.

### **F. 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, HIV/AIDS and Hepatitis Section. 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.

The Florida/Caribbean AIDS Education and Training Center (AETC) offers training modules for case managers. These modules cover various aspects of medical case management. These sessions are available through AETC's E-Learn web page: <http://fcaetc.org/e-learn.php>. Additional information is also available on AETC's Medical Case Management web page: <http://fcaetc.org/medical-case-management.php>.

The first five modules are recommended for ALL new staff and are REQUIRED for all case managers funded through contracts with the HIV/AIDS and Hepatitis Section.

- Introduction to Medical Case Management
- HIV Disease Progression
- Documentation, Progress Notes and Care Plans
- Understanding Laboratory Values
- Preventing Exposure to Opportunistic and Other Infections

A pre- and post-test must be completed and at the end of each training. A certificate will be available for all participants. Please make sure certificates are printed and placed in personnel files.

#### **1. Programmatic Information**

Case management represents a large portion of the Patient Care Section 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 continuous minimum caseload throughout the contracted year of:

- Medical/Non-medical case manager - 60 clients

For a case manager supervisor to be funded under either the Medical or Case Management (Non-medical) line item, they must perform (at a minimum) all of the following tasks:

- Hire and terminate 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

## 2. Definitions

For purposes of the Patient Care Section services contracts, the definitions for medical case management and case management (non-medical) are taken from the Ryan White HIV/AIDS Treatment Extension Act of 2009 Definitions for Eligible Services. See Attachment F for the Definitions for Eligible Services.

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.

## **G. 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. See Appendix D for all Group One clinical measures.

If an area funds Ambulatory/Outpatient Medical Care and/or Medical Case Management through Part B or PCN, 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 HIV/AIDS who are prescribed HAART

The HIV/AIDS and Hepatitis Section will monitor the use of CAREWare for accuracy and completeness of data collections, as described in the [Ryan White HIV/AIDS Program Services Report Instruction Manual](http://hab.hrsa.gov/manageyourgrant/clientleveldata.html) (<http://hab.hrsa.gov/manageyourgrant/clientleveldata.html>), the [Florida HIV/AIDS and Hepatitis Program Eligibility Procedures Manual](#), the HRSA monograph, using data to measure public health performance. <http://hab.hrsa.gov/manageyourgrant/files/datatomeasure2010.pdf>.

## **H. Fee for Service**

In accordance with Section B of the Attachment I, “Manner of Service Provision,” co-payments shall be assessed when practical. If assessed, fees must be reinvested into the HIV program. Refer to Appendix E for details.

Funds cannot be used for client No-Show fees— fees charged by a service provider when a Part B or PCN client did not give prior notice for appointment cancellation. Part B and PCN funds are for payments of services rendered.

## **I. Core/Support Service Limitations**

“Food Bank/Home Delivered Meals” line item is limited to \$35 per client per month for vouchers, gift cards and boxes or bags of food from a food pantry and/or the local rate for home delivered meals.

Each lead agency must create in collaboration with the local consortia a service delivery guideline, which includes service caps for services. The service delivery guideline must be made available to current and new RW or PCN clients for service availability and clarification of services.

## **J. Vital Status**

When closing a status, enter a deceased date, enrollment status, and case closed date, but do not post the entry as a service for medical or non-medical case management. Providers cannot bill for services after a client is deceased or when closing a client file due to death. On becoming aware of a client’s death, enter in CAREWare a new vital status and add any necessary notes in the case notes section and/or comments box.

## SECTION 3: CONTRACT BUDGET

### **A. Budget**

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

In conjunction with the HIV care consortia comprehensive plan, Part B and PCN for Florida's HIV care consortia programs can be used for the following purposes 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 the budget summary and budget narrative of the contract are explained in this section. There are three potential sections for the provider to consider when developing a budget:

#### **1. Administrative Costs (maximum 10 percent of total award)**

- a. 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.

- b. Positions** The budget narrative section must include specific reference information when requesting funding for positions and must be in the following order:
- (1) Position title
  - (2) Job responsibilities as related to the funded work
  - (3) New or existing position
  - (4) Justification for the position
  - (5) Total annual salary
  - (6) Funding amount and percentage of total position funding

- (7) 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 applies especially to case management and other line items funding positions, which must be defined by proposed full time equivalent (FTE).

- c. Fringe Benefits** The following fringe benefits must be included in the budget narrative:
- (1) 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
  - (2) Life/Disability Insurance: List the amount paid by the employer for insurance for the employee.
  - (3) Retirement: List the percentage of the employee's salary as the amount that will be paid by the employer
  - (4) Other: List any benefits for the employee paid by the employer
- d. 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.
- e. 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 completion of the Department Authorization to Incur Travel Expense, form C-676C, and the Department Travel Justification form. General travel also requires a Department travel Voucher for Reimbursement of Out-of-State Travel Expenses, form 676B, be submitted along with original receipts for expenses incurred during officially authorized travel, including items such as car rental, air transportation, parking, meals, lodging, tolls and fares.

Use of Part B and PCN dollars for out-of-state travel is prohibited without prior approval by the Patient Care Supervisor. Requests for out-of-state travel must be submitted in writing to the contract manager and Patient Care Supervisor, using the proper Department forms (outlined above).

- f. Office Expenses and Equipment** Per RFP11-053, Part B and PCN contracts and subcontracted providers will be responsible for supplying, at their own expense, all office equipment, office supplies and over-head costs necessary to perform under the contract, including but not limited to computers, telephones, copiers, fax machines, maintenance and office supplies. Some examples of equipment and office supplies are copy paper, pens, fax machines, laptops, staples, rulers, paper clips, waste baskets, etc. This provision is inclusive to the administrative line item and service line items within the contract.
- g. Communication Expenses** Postage expenses will be allowed and categorized as a communication expense. This expense will be incorporated in the overall 10% administrative cap.

**2. 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 Original Allocation, enter the amount for the fiscal year for each service line item funded. Refer to the Ryan White HIV/AIDS Treatment Extension Act of 2009 Definitions for Eligible Services. See Section 4.F. and Appendix G 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.
- **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

**a. Expenses Not Allowed** Examples of expenses not allowed for Part B and PCN 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 Food Bank/Home Delivered Meals is also prohibited. Refer to the HAB Program Policies for additional information (<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>).

**b. Budget Narrative for Case Management Services** The following provides instructions for the medical case management and the case management (non-medical) budget narrative.

(1) 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's Eligibility Procedures Manual](#).

Also include service information specific to the provider.

- (2) **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, caseloads of case managers, total number of clients served, caps and exceptions.
- (3) **Allocation Methodology:** Include information such as basis for expenditure, review process and needs assessment ranking.
- (4) **Additional Guidelines:** Include description of guiding principles developed by consortium and other related policies or guidelines.
- (5) **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. Contracts must not require case managers to document each 15-minute increment of medical case management services for accountability or reporting.

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

Indirect costs can not be included.

**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 line item 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. Contracts must not require case managers to document each 15-minute increment of medical case management services for accountability or reporting.

This category can be used to fund case management or eligibility.

### **3. Clinical Quality Management Budget (maximum 5 percent of total award)**

Clinical quality management (CQM) will be reimbursed as cost-reimbursement. 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

As the result of CQM becoming a cost reimbursement line item, the following documentation will be required in order for the provider to be paid for these services. Sufficient documentation would entail the following:

- A payroll journal from the payroll company. The staff providing the CQM should be listed on the journal. It should outline the payroll period, how many hours the employee worked, gross salary, and deductions from the employee's paycheck for fringe deductions; a notation should be made to indicate the percent of time allocated to the particular contract.
- Proof of payment to the payroll company.
- Invoices for the fringe benefits (healthcare, dental, life, disability, retirement, etc.). Invoices should show the provider's name, address, period of benefit coverage, amount of the total invoice, amount paid for each applicable employee and individuals' names as they relate to the contract.
- Proof of payment for the corresponding fringe benefit.

FYI - FICA is a straight calculation of 7.65%. No documentation is required for FICA.

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

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. 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 Extension Act of 2009. 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.

**Ambulatory/Outpatient Medical Care-** according to HRSA/HAB Division of Service Systems “Monitoring Standards FAQs,” April 2011, Question 50, pages 11 and 12 includes language that AOMC funding must include provisions for comprehensive primary medical care.

<http://hab.hrsa.gov/manageyourgrant/files/programmonitoringfaq.pdf>

The grantee must provide comprehensive, coordinated primary HIV medical care, and this defines the types of office visits that are allowable under the Ryan White HIV/AIDS Program. The main characteristic of primary care is that the patients consult their primary care doctor for routine check-ups and any time they have a new physical problem. Consequently, primary care practitioners treat patients seeking to maintain optimal health as well as those with acute and chronic physical, mental, and social health issues, including multiple chronic diseases. Chronic illnesses usually treated by primary care providers include: hypertension, heart failure, angina, diabetes, asthma, COPD, depression, anxiety, back pain, arthritis, thyroid dysfunction, and HIV. Primary care is inclusive of HIV, and proof of a relationship with HIV is not needed if these conditions are treated as part of routine primary HIV medical care. Where medical specialty care is required, Ryan White HIV/AIDS Program funding is provided only if the condition is related to the individual’s HIV disease.

Availability of medications for chronic diseases is not a result of allowable vs. non - allowable costs, because the Ryan White HIV/AIDS Program is prescriptive only about limiting the antiretroviral medications to those approved in the PHS Clinical Practice Guidelines.

According to HRSA, funding for support services must contribute to positive medical outcomes. Providers must help document in the budget narrative, individual case notes, and local comprehensive plan that support service funds are contributing to positive medical outcomes for clients.

## **D. Allowable Funded Services**

### **HRSA’s HIV-Related Service Categories**

The Ryan White HIV/AIDS Treatment Extension Act of 2009 Definitions for Eligible Services (see Appendix G) prepared by HRSA describes allowable Part B services. Please refer to this information and the HRSA Program Policy Notices during contract development and negotiation. HRSA program policy notices are available online at <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>.

Attachment 4 (Budget), Attachment 2 for CHDs, list the core and support services allowed to be funded under the Part B contracts within Florida.

## **E. 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 CQM 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 of the contract and subcontracts, to comply with HRSA requirements.

## **F. Budget Revisions**

Budget revisions to patient care contracts do not require a contract amendment. However, the provider must report all budget revisions using the contract budget summary and complete the columns labeled Increase/Decrease and Revised Allocation. In addition, the provider must submit a narrative justifying the reason for the increase or decrease. The Department contract manager will approve and sign the revised budget and justification narrative.

The Part B Budget Narrative, detailing the Administration, Direct Services, Support Services and CQM line items, must be updated to reflect the current budget revision. If funds are being moved from a core service to a support service, the contract manager must send the budget revision to your area Community Programs Coordinator for review prior to approval. Also notify the Community Programs Coordinator that the Part B Budget Narrative has been updated. 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 CQM categories into the Direct Services category only and may not be used to increase Administrative or CQM costs.

Any budget revisions requested within the last 30 days of the contract must be approved, in writing, by the HIV/AIDS and Hepatitis Section, Operations and Management's Contract Unit. Supporting budget narrative must also be revised and provided.

Budget revisions cannot be retroactive. If the line item is overdrawn, the provider must change the payment amount to the amount available in the line item. The revised amount added to the line item can only be used for expenditures incurred after the date the revised amount is approved by the contract manager.

The Department of Health's Bureau of Finance and Accounting recognizes that there are legitimate instances where, due to the type of services rendered, the provider will not be able to determine exactly how much will be expended and may run over a line item amount. In those cases, if prior notice is given to Finance and Accounting, Disbursements will work with the program office, contract manager and provider to accept a retroactive budget revision. This is not a universal practice and exceptions will only be made in special cases.

Once a revision is reviewed and approved, the contract manager will place the revised budget summary, budget narrative, and the signed and approved 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 via AIMS 2.0
- HIV/AIDS and Hepatitis Contracts Unit
- Community Programs Coordinator

**G. Quarterly Financial Report (QFR)**

A QFR is required with details on how the administrative dollars have been spent. A template for the quarterly report has been provided as guidance and the Excel form is available in each area folder on the Department shared drive. QFRs are submitted according to contract provisions. Contract managers will review back-up documentation for the QFRs according to the Contract Manager's Financial Checklist included in the contract manager's handbook, and ensure that all expenditures are allowable under the terms of the contract.

## SECTION 4: CONTRACT MONITORING

### A. Monitoring Lead Agencies

All lead agencies must be monitored once during the contract period. Part B and PCN contracts can be monitored any time after the first 90 days (after receipt of the provider's first Quarterly Financial Report) but before the final 90 days of the contract end date. Combined monitoring of Part B and PCN contracts is allowed. Additional monitoring may be conducted as needed to ensure programs comply with contract requirements. The HIV/AIDS and Hepatitis Section's Community Programs Coordinators will monitor county health departments serving as the lead agency.

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 the contract manager. The contract manager will save the documentation on the department share drive.

For Department contract managers, a lead agency monitoring template containing the universal, fiscal and programmatic monitoring is provided on the shared drive under the folder labeled "Monitoring Templates." The template should only be modified to reflect additional contract provisions specific to an area. Standards for direct care services not funded by the contract may be removed from the programmatic portion of monitoring tool. In the column "Ratings Based Upon," all provisions must be verified either by direct observation by the contract manager or by supporting documentation. Comments are required when provisions are rated either "Unacceptable" or "Exceeds Expectations."

All lead agency monitoring documents, including the completed monitoring tools, the monitoring report, the letter to the provider and page one of the updated DH 1122 form, are to be placed in the "Completed Contract Monitorings" folder on the shared drive. After the documents are posted to the shared drive, the contract manager should notify via email Wanda Washington in the Contracts Unit of the HIV/AIDS and Hepatitis Section and their Community Programs Coordinator.

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 the expenses are charged to the correct line item.

Quarterly Financial Reports are submitted according to contract provisions. Contract managers will review back-up documentation for the Quarterly Financial Reports according to the Contract Manager's Financial Checklist included in the contract manager's handbook and ensure that all expenditures are allowable under the terms of the contract.

## **B. Monitoring of Subcontracted Providers**

Lead agencies are responsible for:

- Providing a list of projected monitoring dates to the 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
- Reviewing and monitoring the data providers are required to enter into CAREWare
- Ensuring that subcontractors— especially new subcontractors or subcontractors that have received an increased contract payment amount of 25 percent or more— have sufficient infrastructure to support their contracts and meet their deliverables. Assessing the viability of subcontractors includes either 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. The area HIV/AIDS Program Coordinator and contract manager should be notified if there are concerns about viability.

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.

Contract Managers are responsible for:

- Obtaining a list of projected monitoring dates from the lead agency within 30 days of the start of contract
- Monitoring the lead agency for compliance with the contract and providing the monitoring reports to the Department's Contracts Unit and area Community Programs Coordinator within the first 120 days of the contract
- Supporting lead agencies with technical assistance as needed
- Reviewing and monitoring the data lead agencies are required to enter into CAREWare and the reports required for submission to Reporting and Information Systems (via AIMS 2.0), as outlined in Section 5
- Attending departmental contract manager conference calls

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

## **C. HRSA Monitoring Standards**

HRSA has designed standards to provide clear guidance to Part B grantees and providers on HRSA/HAB expectations in terms of monitoring provider performance. The standards provide benchmarks that meet both federal legislative and regulatory guidelines and represent sound practice. The standards assume that a direct service provider can be a lead agency that administers the program or a subcontracted provider. They are not designed for use with subcontractors that provide professional or technical support, such as needs assessment or quality management. The standards have been modified here to apply to both Part B and PCN contracts and other written agreements. “Provider Responsibility” provisions are required of all funded providers.

In the context of the HRSA standards, “grantee” refers to the HIV/AIDS and Hepatitis Program or its designee, including the department contract manager. “Agreements” refer to contracts, subcontracts, memoranda of agreement or other similar written agreement and Schedule C instruction letters. “Contract Manager” can be either the department contract manager or the contract manager for the lead agency responsible for monitoring subcontractors or other direct service providers with whom they have signed agreements.

## **D. HRSA Universal Standards**

### **I. Access to Care**

- 1. Standard:** Structured and ongoing efforts to obtain input from clients in the design and delivery of services

#### **Performance Measure/Method:**

- Documentation of Consumer Advisory Board and public meetings, including minutes, and/or
- Documentation of existence and appropriateness of a suggestion box or other client input mechanism and/or
- Documentation of content, use and confidentiality of a client satisfaction survey or focus groups conducted at least annually

#### **Contract Manager Responsibility:**

- Review documentation at the provider level to determine methods used for obtaining consumer input into the delivery of services

#### **Provider Responsibility:**

- Maintain file of materials documenting Consumer Advisory Board membership and meetings, including minutes, and/or
- Regularly implement client satisfaction survey tool, focus groups and/or public meetings, with analysis and use of results documented and/or
- Maintain visible suggestion box or other client input mechanism

- 2. Standard:** Provision of services regardless of an individual’s ability to pay for the service

#### **Performance Measure/Method:** Agency billing and collection policies and procedures that do not:

- Deny services for non-payment

- Require full payment prior to service
- Include any other procedure that denies services for non-payment

**Contract Manager Responsibility:**

- Review agency's billing, collection, co-pay and sliding fee policies and procedures to ensure that they do not result in denial of services
- Investigate any complaints against the agency for denial of services
- Review file of refused clients and client complaints (refer to the HIV/AIDS and Hepatitis Section Grievance and Appeal Policy and Procedure for guidance, Appendix K)

**Provider Responsibility:**

- Have billing, collection, co-pay and sliding fee policies that do not act as a barrier to providing services regardless of the client's ability to pay
- Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients with documentation of complaint review and decision reached

3. **Standard:** Provision of services regardless of the current or past health condition of the individual to be served

**Performance Measure/Method:** Documentation of eligibility and clinical policies to ensure that they do not:

- Permit denial of services due to pre-existing conditions
- Permit denial of HIV services due to non-HIV-related conditions (primary care)
- Provide any other barrier to care due to a person's past or present health condition

**Contract Manager Responsibility:**

- Review agency eligibility and clinical policies
- Investigate any complaints of agency "dumping" or "cherry picking" patients

**Provider Responsibility:**

- Maintain files of eligibility and clinical policies
- Maintain file of individuals refused services

4. **Standard:** Provision of services in a setting accessible to low-income individuals with HIV disease

**Performance Measure/Method:**

- A facility that is handicapped accessible, accessible by public transportation
- Policies and procedures that provide, by referral or vouchers, transportation if facility is not accessible to public transportation
- No policies that may act as a barrier to care for low-income individuals

**Contract Manager Responsibility:**

- Inspect service provider accessibility and access to public transportation
- Review policies and procedures for providing transportation assistance if facility is not accessible by public transportation

**Provider Responsibility:**

- Comply with [Americans with Disabilities Act](#) requirements

- Ensure that the facility is accessible by public transportation or provide for transportation assistance

**5. Standard:** Efforts to inform low-income individuals of the availability of HIV-related services and how to access them

**Performance Measure/Method:** Availability of informational materials about agency services and eligibility requirements including:

- Newsletters
- Brochures
- Posters
- Community Bulletins
- Any other types of promotional materials

**Contract Manager Responsibility:** Review documents indicating activities for promotion and awareness of the availability of HIV services

**Provider Responsibility:** Maintain file documenting agency activities for the promotion of HIV services to low-income individuals including copies of HIV program materials promoting services and explaining eligibility requirements

## II. Eligibility Determination/Screening

- 1. Standard:** Screening and reassessment of clients to determine eligibility as specified by the state:
- Screening of clients to determine eligibility for Part B and PCN services within a predetermined timeframe
  - Reassessment of clients every six months to determine continued eligibility

**Performance Measure/Method:**

- Documentation of eligibility required in client records, with copies of documents (e.g., proof of HIV status, proof of residence, proof of income eligibility based on the income limit established by the state, proof of insurance, uninsured or underinsured using approved documentation as required by the state)
- Eligibility determination and enrollment forms for other third party payers such as Medicaid and Medicare
- Eligibility policy and procedures on file
- Documentation that all staff involved in eligibility determination has participated in required training
- Agency client data reports are consistent with eligibility requirements specified by the funder
- Documentation of reassessment of client's eligibility status every six months
- Training provided by the grantee/contractor to ensure understanding of the policy and procedures

**Contract Manager Responsibility:**

- Conduct site visits to review client files for appropriate documentation that meets the requirements

- Monitor the receipt and use of third party payments by providers as an indication of the use of third party payers by providers
- Review data reports for accuracy
- Use monthly and quarterly progress reports to identify and address problems in the process of determining eligibility
- Monitor reports that include client utilization and expenditure reports by agency and by service category

**Provider Responsibility:**

- Develop and maintain client files that contain documentation of client's eligibility, including the following:
    - HIV/AIDS diagnosis
    - Low-income
    - Uninsured or underinsured status (insurance verification as proof)
    - Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare
    - For underinsured, ineligibility for service
    - Proof of compliance with eligibility as defined by the state
  - Document that the process for establishing eligibility, assessment and reassessment takes place within time frames established by the state
  - Document that all staff involved in eligibility determination have participated in required training
  - Ensure agency client data reports are consistent with eligibility requirements by funder which demonstrates eligible clients are receiving allowable services
- 2. Standard:** Eligibility policies that do not deem a veteran living with HIV ineligible for Part B or PCN services due to eligibility for Department of Veterans Affairs (VA) health care benefits

**Performance Measure/Method:** Documented evidence that the agency's eligibility policies (written or verbal) do not consider VA health benefits as the veteran's primary insurance and deny access to Part B or PCN services citing "payer of last resort"

**Contract Manager Responsibility:** Ensure those providers that are funded to assess eligibility are aware of and are consistently implementing the veteran classification policy

**Provider Responsibility:** Ensure that policies and procedures classify veterans receiving VA health benefits as uninsured, thus exempting these veterans from the "payer of last resort" requirement

**III. Anti-Kickback Statute**

- 1. Standard:** Demonstrated structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally or state funded program

**Performance Measure/Method:**

- Employee Code of Ethics including:
  - Conflict of Interest
  - Prohibition on use of agency property, information or position without approval or to advance personal interest

- Fair dealing - engaged in fair and open competition
- Confidentiality
- Protection and use of company assets
- Compliance with laws, rules and regulations
- Timely and truthful disclosure of significant accounting deficiencies
- Timely and truthful disclosure of non-compliance

**Contract Manager Responsibility:**

- Require by contract that providers have:
  - Employee Code of Ethics
  - For Medicare and Medicaid providers, a Corporate Compliance Plan, bylaws and policies that include ethics standards or business conduct practices
- During site visits, verify compliance with contract anti-kickback conditions

**Provider Responsibility:**

- Maintain and review file documentation of:
  - Corporate Compliance Plan (required by HCFA if providing Medicare- or Medicaid-reimbursable services)
  - Personnel policies
  - Code of Ethics or Standards of Conduct
  - Bylaws and board policies
  - File documentations of any employee or board member violation of the Code of Ethics or Standards of Conduct
  - Documentation of any complaint of violation of the Code of Ethics or Standards of Conduct and its resolution
- For not-for-profit contractor organizations, ensure documentation of agency bylaws, Board Code of Ethics and business conduct practices

2. **Standard:** Prohibition of employees (as individuals or entities) from soliciting or receiving payment in kind or cash for the purchase, lease ordering or recommending the purchase, lease or ordering of any goods, facility service or items

**Performance Measure/Method:** Any documentation required by the Compliance Plan or employee conduct standards that prohibits employees from receiving payments in kind or cash from suppliers and contractors of goods or services

**Contract Manager Responsibility:** Maintain file documentation and do on-site assessment that cover:

- Agreements
- Recruitment policies and procedures that discourage signing bonuses
- Conflict of interest
- Prohibition of exorbitant signing packages
- Policies that discourage the use of two charge masters, one for self-pay clients and a higher one for insurance companies
- Proof of employee background checks
- Purchasing policies that discourage kickbacks and referral bonuses

**Provider Responsibility:**

- Have adequate policies and procedures to discourage soliciting cash or in-kind payments for:
  - Awarding contracts
  - Referring clients
  - Purchasing goods or services and/or
  - Submitting fraudulent billings
  - Compliance audits or compliance checks
- Have employee policies that discourage:
  - The hiring of persons with felony criminal records relating to or are being investigated for Medicare or Medicaid fraud
  - Large signing bonuses

**IV. Provider Accountability**

- 1. Standard:** Proper stewardship of all Part B and PCN funds including compliance with programmatic requirements

**Performance Measure/Method:** Policies, procedures and agreements that require:

- Timely submission of detailed fiscal reports by funding source, with expenses allocated by service category
- Timely submission of programmatic reports
- Documentation of method used to track unobligated balances and carryover funds
- A documented reallocation process
- Report of total number of funded providers
- A-133 or single audit
- Auditor management letter

**Contract Manager Responsibility:**

- Include in provider contracts clear and concise language that outlines programmatic and fiscal requirements, including requirements for:
  - A programmatic and fiscal monitoring system which includes monthly and or quarterly timeframes for ensuring compliance
  - Reports that provide financial information as needed to enable grantee to meet federal requirements
  - An independent audit which shall be an A-133 audit for those meeting financial thresholds
- Review A-133 audits or other audits when submitted by providers

**Provider Responsibility:**

- Meet contracted programmatic and fiscal requirements, including:
  - Provide financial reports that specify expenditures by service category and use of Part B or PCN funds as specified by the grantee
  - Develop financial provider Policies and Procedures Manual that meet Part B and PCN program requirements
  - Closely monitor any subcontractors
  - Commission independent audits; for those meeting thresholds, audits that meet A-133 requirements

2. **Standard:** Accountability by the lead agencies for the expenditure of funds it shares with subcontractors

**Performance Measure/Method:**

- A copy of each agreement
- Fiscal and program site visit reports and action plans
- Audit reports
- Documented reports that track funds by PCN and Part B formula, supplemental and EC service categories
- Documented reports that track unobligated balance
- Documented reallocation process
- Report of total number of funded subcontractors
- Lead agency A-133 or single audit conducted annually
- Auditor management letter

**Contract Manager Responsibility:**

- Include clear and concise contract language that outlines programmatic and fiscal requirements
- Review A-133 and other audits submitted by providers

**Provider Responsibility:** Establish and implement:

- Fiscal and general policies and procedures that include compliance with federal, Part B and PCN programmatic requirements
- Flexible fiscal reporting systems that allow the tracking of unobligated balances and detail service reporting of funding sources
- Timely submission of independent audits (A-133 audits if required) to grantee

3. **Standard:** Business management systems that meet the requirements of the Office of Management and Budget, Code of Federal Regulations and programmatic expectations outlined in the Part B Notice of Award

**Performance Measure/Method:**

- Review of provider agreements
- Fiscal and program site visit reports and action plans
- Policies and procedures that outline compliance with federal, Part B and PCN programmatic requirements
- Independent audits
- Auditor management letter

**Contract Manager Responsibility:** Require provider's compliance with the requirements in the following documents:

- [45 CFR 74](#) (Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations and Commercial Organizations) or [45 CFR 92](#) (Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments) or
- [2 CFR 215 or 230 or 220](#) (Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-Profit Organizations [OMB

Circular A-110]; Cost Principles for Non-Profit Organizations [OMB Circular A-122]; Cost Principles for Education Institutions [OMB Circular A-21])

- Department of Health and Human Services (HHS) Grant Policy Statement (Terms and Conditions)
- Notice of Award Program conditions, terms and reporting requirements

**Provider Responsibility:** Ensure that the following are in place: documented policies and procedures and fiscal/programmatic reports that provide effective control over and accountability for all funds in accordance with federal, Part B and PCN programmatic requirements

- 4. Standard:** Responsibility for activities that are supported under the Part B and PCN programs as outlined by Office of Management and Budget, Code of Federal Regulations, HHS Grant Policy Statement (Terms and Conditions) and Part B Notice of Award

**Performance Measure/Method:** Desk audits of budgets, yearly expenses, programmatic reports; audit reports or on-site review when assessing compliance with fiscal and programmatic requirements

**Contract Manager Responsibility:**

- Monitor to enforce and ensure compliance
- Ensure maintenance of documentation that supports proof of compliance
- Include contract language that requires compliance with OMB, CFR, program assurances, Part B Notice of Award terms and standards

**Provider Responsibility:** Ensure policies and procedures and flexible fiscal and programmatic systems that can meet compliance with federal, Part B and PCN programmatic requirements

**V. Reporting**

- 1. Standard:** Submission of standard reports as required in circulars as well as program-specific reports (Part B only)

Required Report	Due Date
Implementation Plan	90 days after budget start period
Providers/Sub-contractor list	90 days after budget start period
WICY Report	120 days after end of budget period
Final Annual Progress Report	120 days after end of budget period
Final Expenditures	150 days after end of budget period
Mid-year progress report	210 days after budget start period
Calendar year RSR	March of following calendar year

**Performance Measure/Method:** Records that contain and adequately identify the source of information pertaining to:

- Federal award revenue, expenses, obligations, unobligated balances, assets, outlays, program income and interest
- Client level data

- Aggregate data on services provided, clients served, client demographics and selected financial information

**Contract Manager Responsibility:**

- Assess financial and program performance of providers who are required to submit standard reports

**Provider Responsibility:** Ensure:

- Timely submission of provider reports
- File documentation or data containing analysis of required reports to determine accuracy and any reconciliation with existing financial or programmatic data
- Submission of periodic financial reports that document the expenditure of Part B or PCN funds, positive and negative spending variances and how funds have been reallocated to other line-items or service categories

**VI. Monitoring**

1. **Standard:** Any provider or individual receiving Part B or PCN funding is required to monitor for compliance with federal and state requirements and programmatic expectations

**Performance Measure/Method:** Development and consistent implementation of policies and procedures that establish uniform administrative requirements governing the monitoring of agreements

**Contract Manager Responsibility:** Document in provider agreements the frequency, reports and expectations of monitoring activities

**Provider Responsibility:**

- Participate in and provide all material necessary to carry out monitoring activities
- Monitor any service contractors for compliance with federal, state and programmatic requirements

2. **Standard:** Monitoring activities expected to include annual site visits of all providers and subcontractors

**Performance Measure/Method:** Review of the following program monitoring documents and actions:

- Policies and procedures
- Tools, protocols or methodologies
- Reports
- Corrective action plans
- Progress on meeting goals of corrective action plans

**Contract Manager Responsibility:**

- Use a combination of several of the following to monitor program compliance: program reports, annual site visits, client satisfaction reviews, capacity development/technical assistance and chart or records reviews

- Keep to a reasonable level the time and resources providers must spend to meet their reporting obligations
- Review the following program monitoring documents:
  - Policies and procedures
  - Tool, protocol or methodology
  - Reports
  - Corrective site action plan
  - Progress on meeting goals of corrective action plan

**Provider Responsibility:**

- Establish policies and procedures to ensure compliance with federal and programmatic requirements
- Submit auditable reports
- Provide the grantee access to financial documentation

- 3. Standard:** Performance of fiscal monitoring activities to ensure that Part B and PCN funding is being used for approved purposes

**Performance Measure/Method:** Review of the following fiscal monitoring documents and actions:

- Fiscal monitoring policy and procedures
- Fiscal monitoring tool or protocol
- Fiscal monitoring reports
- Fiscal monitoring corrective action plans
- Compliance with goals of corrective action plans

**Contract Manager Responsibility:**

- Have documented evidence of:
  - Fiscal monitoring activities
  - Records reviews
  - Supporting documentation of paid expenditures
  - An annual financial audit by a qualified independent accountant
- Have on file a copy of all provider procurement documents including subcontractor agreements and fiscal and programmatic site visit reports

**Provider Responsibility:** Have documented evidence that Part B or PCN funds have been used for allowable services and spent in accordance with federal and state requirements and expectations

- 4. Standard:** HRSA funds may not be used to pay the salary of an individual at a rate in excess of \$179,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the provider

**Performance Measure/Method:**

- Identification and description of individual employee salary expenditures to ensure that salaries are within the HRSA salary limit
- Determine whether individual staff receives additional HRSA income through other contracts

**Contract Manager Responsibility:**

- Monitor staff salaries to determine whether the salary limit is being exceeded

- Monitor prorated salaries to ensure that the salary when calculated at 100 percent does not exceed the HRSA salary limit
- Monitor staff salaries to determine that the salary limit is not exceeded when the aggregate salary funding from other HRSA sources, including BPHC, MCHB, Ryan White A,B,C,D and F, do not exceed the limitation
- Review payroll reports, payroll allocation journals and employee contracts
- Interview employees if payroll or income documents are not available from provider

**Provider Responsibility:**

- Monitor staff salaries to determine if salary limit is being exceeded
- Monitor prorated salaries to ensure that salary when calculated at 100 percent does not exceed the HRSA salary limit
- Monitor staff salaries to determine that salary limit is not exceeded when aggregate salary funding from other federal sources, including all parts of RW, BPHC and MCHB, do not exceed the limitation
- Review payroll reports, payroll allocation journals and employee contracts

- 5. Standard:** If an individual is under the salary cap limitation, fringe is applied as usual. If individual is over the salary cap limitation, fringe is calculated on the adjusted base salary

**Performance Measure/Method:**

- Identification of individual employee fringe benefit allocation

**Contract Manager Responsibility:**

- Monitor to ensure when an employee salary exceeds the salary limit, the fringe benefit contribution is limited to the percentage of the maximum allowable salary

**Provider Responsibility:**

- Monitor to ensure that when an employee salary exceeds the salary limit, the fringe benefit contribution is limited to the percentage of the maximum allowable salary

- 6. Standard:** Corrective actions taken when provider outcomes do not meet program objectives and grantee expectations, which may include:

- Improved oversight
- Redistribution of funds
- A corrective action letter
- Sponsored technical assistance

**Performance Measure/Method:**

- Review of corrective action plans
- Review of resolution of issues identified in corrective action plan
- Policies that describe actions to be taken when issues are not resolved in a timely manner

**Contract Manager Responsibility:**

- Implement monitoring policies that require a compliance report that lists in order of gravity the identified non-compliance activities, requires a corrective action plan and establishes a time limit for response and implementation of measures that will bring provider into compliance

- Provide the grantee with monitoring reports, corrective action plans and progress reports on the resolution of any findings of a monitoring report

**Provider Responsibility:** Prepare and submit:

- Timely and detailed response to monitoring findings
- Timely progress reports on implementation of corrective action plan

## **E. HRSA Fiscal Monitoring Standards**

### **I. Limitation on Uses of Part B and PCN Funding**

- 1. Standard:** Administrative expenses that total not more than 10 percent of Part B or PCN service dollars

**Performance Measure/Method:**

- Review of provider budgets to ensure proper designation and categorization of administrative costs
- Calculation of the administrative costs for each provider

**Contract Manager Responsibility:** Maintain documentation on all providers, including their current operating budgets and expense/allocation reports, with sufficient detail to identify and calculate administrative expenses

**Provider Responsibility:** Prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses

- 2. Standard:** Appropriate provider assignment of Part B and PCN administrative expenses with administrative costs to include:

- Usual and recognized overhead activities, including rent, utilities and facility costs
- Costs of management oversight of specific programs funded by Part B or PCN including program coordination; clerical, financial and management staff not directly related to patient care; program evaluation; liability insurance; audits; and computer hardware/software not directly related to patient care
- For institutions subject to 2 CFR Part 215 ([OMB 21](#), “Cost Principles for Educational Institutions”) the term “facilities and administration” is used to mean indirect cost

**Performance Measure/Method:** Review of provider administrative budgets and expenses to ensure that all expenses are allowable

**Contract Manager Responsibility:**

- Obtain and keep on file current provider operating budgets with sufficient detail to review program and administrative expenses and ensure appropriate categorization of costs
- Review expense reports to ensure that all administrative costs are allowable

**Provider Responsibility:**

- Prepare project budget that meets administrative cost guidelines

- Provide expense reports that track administrative expenses with sufficient detail to permit review of administrative cost elements

## II. Unallowable Costs

1. **Standard:** Definitions of unallowable costs made available by the grantee to all Part B and PCN providers

**Performance Measure/Method:**

- Signed agreements that define and specifically forbid the use of Part B or PCN funds for unallowable expenses
- Contract manager review of provider budgets and expenditures to ensure that they do not include any unallowable costs

**Contract Manager Responsibility:**

- Definitions of unallowable costs are included in all provider agreements and purchase orders
- Include in financial monitoring a review of provider expenses to identify any unallowable costs
- Require provider budgets and expense reports with sufficient budget justification and expense detail to document that they do not include unallowable costs

**Provider Responsibility:**

- Maintain a file with signed agreements that specify unallowable costs
- Ensure that budgets do not include unallowable costs
- Ensure that expenditures do not include unallowable costs
- Provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs

2. **Standard:** No use of Part B or PCN funds to purchase or improve land or to purchase, construct or permanently improve any building or other facility (other than minor remodeling)

**Performance Measure/Method:** Implementation of actions specified in II.1

**Contract Manager Responsibility:** Carry out actions specified in II.1

**Provider Responsibility:** Carry out provider actions specified in II.1

3. **Standard:** No cash payments to service recipients

**Note:** A cash payment is the use of some form of currency (paper or coins). Gift cards have an expiration date; therefore they are not considered to be cash payments

**Performance Measure/Method:**

- Implementation of actions specified in II.1
- Review of Standards of Care and other policies and procedures for service categories involving payments made on behalf of individuals to ensure that no direct payments are made to individuals (e.g., emergency financial assistance, transportation, health insurance premiums, medical or medication co-pays and deductibles, food and nutrition)

- Review of expenditures by providers to ensure that no cash payments were made to individuals

**Contract Manager Responsibility:**

- Carry out actions specified in II.1
- Ensure that Standards of Care for service categories involving payments made on behalf of clients forbid cash payments to service recipients

**Provider Responsibility:**

- Carry out provider actions specified in II.1
- Maintain documentation of policies that forbid use of Part B and PCN funds for cash payments to service recipients

4. **Standard:** No use of Part B or PCN funds to develop materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual

**Performance Measure/Method:** Implementation of actions specified in II.1

**Contract Manager Responsibility:** Carry out actions specified in II.1

**Provider Responsibility:** Carry out provider actions specified in II.1

5. **Standard:** No use of Part B or PCN funds for the purchase of vehicles without written Grants Management Officer (GMO) approval

**Performance Measure/Method:**

- Implementation of actions specified in II.1
- Where vehicles were purchased, review files for written permission from GMO

**Contract Manager Responsibility:**

- Carry out actions specified in II.1
- If any vehicles were purchased, maintain file documentation of permission of GMO to purchase a vehicle

**Provider Responsibility:**

- Carry out Provider actions specified in II.1
- If vehicle purchase is needed, seek grantee assistance in obtaining written GMO approval and maintain document in file

6. **Standard:** No use of Part B funds for:

- Non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.)
- Broad-scope awareness activities about HIV services that target the general public

**Performance Measure/Method:**

- Implementation of actions specified in II.1

- Review of program plans, budgets and budget narratives for marketing, promotions and advertising efforts to determine whether they are appropriately targeted to geographic areas and/or disproportionately affected populations rather than targeting the general public

**Contract Manager Responsibility:**

- Carry out actions specified in II.1
- Review program plans and budget narratives for any marketing or advertising activities to ensure that they do not include unallowable costs

**Provider Responsibility:**

- Carry out provider actions specified in II.1
- Prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities

7. **Standard:** No use of Part B or PCN funds for outreach activities that have HIV prevention education as their exclusive purpose

**Performance Measure/Method:** Implementation of actions specified in II.1

**Contract Manager Responsibility:**

- Carry out actions specified in II.1
- Require a detailed narrative program plan of outreach activities from providers and contractors to ensure that their purpose goes beyond HIV prevention education to include testing and early entry into care

**Provider Responsibility:**

- Carry out provider actions specified in II.1
- Provide a detailed program plan of outreach activities that demonstrates how the outreach goes beyond HIV prevention education to include testing and early entry into care

8. **Standard:** No use of Part B or PCN funds for influencing or attempting to influence members of Congress and other federal or state personnel

**Performance Measure/Method:**

- Implementation of actions specified in II.1
- Review lobbying certification and disclosure forms for providers

*Note:* Forms can be obtained from the CFR website: <http://ecfr.gpoAccess.gov>

**Contract Manager Responsibility:**

- Carry out actions specified in II.1
- Ensure that provider staff are familiar and in compliance with prohibitions on lobbying with federal and state funds

**Provider Responsibility:**

- Carry out provider actions specified in II.1
- Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds

**9. Standard:** No use of Part B or PCN funds for foreign travel

**Performance Measure/Method:** Implementation of actions specified in II.1

**Contract Manager Responsibility:**

- Carry out actions specified in II.1
- Request a detailed narrative from providers on budgeted travel

**Provider Responsibility:**

- Carry out provider actions specified in II.1
- Maintain a file documenting all travel expenses paid by Part B or PCN funds

**10. Standard:** No use of Part B or PCN funds to pay any costs associated with the creation, capitalization or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools) or to pay any amount expended by a state under [Title XIX](#) of the Social Security Act

**Performance Measure/Method:** Implementation of actions specified in II.1

**Contract Manager Responsibility:** Carry out actions specified in II.1.

**Provider Responsibility:** Carry out Provider actions specified in II.1

### III. Income from Fees for Services Performed

**1. Standard:** Use of Part B, PCN and third party funds to maximize program income from third party sources and ensure that Part B and PCN are the payers of last resort. Third party funding sources include:

- Medicaid
- State Children's Health Insurance Programs
- Medicare (including the Part D prescription drug benefit)
- Veteran's Administration
- Private insurance (including medical, drug, dental and vision benefits)

**Performance Measure/Method:**

- Information in client files that includes proof of screening for insurance coverage
- Documentation of policies and consistent implementation of efforts to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance or other programs
- Documentation of procedures for coordination of benefits by grantee and providers

**Contract Manager Responsibility:** Ensure that providers are maximizing third party reimbursements, including:

- Requirement in contract or subcontract or through another mechanism that providers maximize and monitor third party reimbursements
- Requirement that providers document in client files how each client has been screened for and enrolled in eligible programs

- Monitoring to determine that Part B and PCN are serving as the payers of last resort, including review of client files and documentation of billing, collection policies and procedures and information on third party agreements

**Provider Responsibility:**

- Have policies and staff training on the requirement that Part B and PCN are the payers of last resort and how that requirement is met
- Require that each client be screened for insurance coverage and eligibility for third party programs and helped to apply for such coverage with documentation of this in client file
- Carry out internal reviews of files and billing system to ensure that Part B or PCN resources are used only when a third party payer is not available
- Establish and maintain medical practice management systems for billing

2. **Standard:** Provider billing and collection from third party payers, including Medicare and Medicaid, so that payer of last resort requirements are met

**Performance Measure/Method:**

- Inclusion in agreements of language that requires billing and collection of third party funds
- Review of the following provider systems and procedures:
  - Billing and collection policies and procedures
  - Electronic or manual system to bill third party payers
  - Accounts receivable system for tracking charges and payments for third party payers

**Contract Manager Responsibility:**

- Include provisions in agreements that require billing and collection of third party funds
- Where appropriate, require reports from providers on collections from third party payers
- Where the lead agency is a provider of billable or pharmacy services, carry out same direct efforts as providers

**Provider Responsibility:** Establish and consistently implement in medical offices and pharmacies:

- Billing and collection policies and procedures
- Billing and collection process and/or electronic system
- Documentation of accounts receivable

3. **Standard:** Provider participation in Medicaid and certification to receive Medicaid payments required, unless waived by the Secretary of Health and Human Services

**Performance Measure/Method:**

- Review of each provider's individual or group Medicaid numbers
- If provider is not currently certified to receive Medicaid payments, documentation of efforts under way to obtain documentation and expected timing

**Contract Manager Responsibility:**

- Maintain documentation of provider Medicaid certification
- Ensure that where providers that are not certified, a waiver is sought from the Secretary of HHS

**Provider Responsibility:**

- Document and maintain file information on provider agency Medicaid status
- Maintain file of contracts with Medicaid insurance companies
- If no Medicaid certification, document current efforts to obtain such certification
- If certification not feasible, request a waiver where appropriate

4. **Standard:** Ensure billing, tracking and reporting of program income (including drug rebates) by providers that provide reimbursable expenses

**Performance Measure/Method:**

- Review of provider billing, tracking and reporting of program income, including drug rebates
- Review of program income reported by the provider in annual reports

**Contract Manager Responsibility:**

- Monitor providers to ensure appropriate billing and tracking of program income, including drug rebates
- Review provider reporting of program income

**Provider Responsibility:** Bill, track and report to the contract manager all program income (including drug rebates) billed and obtained

5. **Standard:** Ensure service provider retention of program income derived from Part B- and PCN-funded services and use of such funds in one or more of the following ways:
- Funds added to resources committed to the project or program and used to further eligible project or program objectives
  - Funds used to cover program cost

*Note:* Program income funds are not subject to the limitations on administration (10 percent), clinical quality management (5 percent) or core services (75 percent minimum). For example, all program income can be spent on administration of the Part B or PCN programs

**Performance Measure/Method:**

- Review of provider systems for tracking and reporting program income generated by Part B or PCN-funded services
- Review of expenditure reports from provider regarding collection and use of program income
- Monitoring of medical practice management system to obtain reports of total program income derived from Part B or PCN activities

**Contract Manager Responsibility:**

- Monitor provider receipt and use of program income to ensure use for program activities

**Provider Responsibility:**

- Document billing and collection of program income
- Report program income documented by charges, collections and adjustment reports or by the application of a revenue allocation formula

#### IV. Imposition and Assessment of Client Charges

1. **Standard:** Unless waived, ensure provider policies and procedures that specify charges to clients for services, which may include a documented decision to impose only a nominal charge

*Note:* This expectation applies to lead agencies that also serve as direct service providers

**Performance Measure/Method:** Review of provider policies and procedures to determine:

- Existence of a provider sliding fee discount policy
- Sliding fee discount schedule, based on current Federal Poverty Level (FPL) including cap on charges
- Client applications for sliding fee discount
- Actual client charges made and received
- System used for charges, payments and adjustments

**Contract Manager Responsibility:**

- Require that providers develop and then review:
  - Sliding fee discount policy and schedule
  - Eligibility criteria and sliding fee eligibility application form
  - Description of medical information system used to record patient charges, payments and adjustments
- Review documentation on provider fee schedule and narrative on agency medical information system to show that charges have been incurred

**Provider Responsibility:** Establish, document and have available for review:

- Sliding fee discount policy
- Current fee schedule
- Sliding fee eligibility applications in client files
- Fees charged and paid by clients
- Process for charging, obtaining and documenting client charges through a medical practice information system manual or electronic

2. **Standard:** No charges imposed on clients with incomes below 100 percent of the FPL

**Performance Measure/Method:** Review of provider sliding fee discount policy and schedule to ensure that clients with incomes below 100 percent of the FPL are not charged for services

**Contract Manager Responsibility:**

- Review provider sliding fee discount policy and schedule, criteria and form to ensure that clients with incomes below 100 percent of the FPL are not to be charged for services
- Review client files and documentation of actual charges and payments to ensure that the policy is being correctly and consistently enforced and clients below 100 percent of FPL are not being charged for services

**Provider Responsibility:** Document that:

- Sliding fee discount policy and schedule do not allow clients below 100 percent of FPL to be charged for services

- Personnel are aware of and follow the policy and fee schedule
  - Policy is being consistently followed
3. **Standard:** Charges to clients with incomes greater than 100 percent of FPL that are based on a discounted fee schedule and a sliding fee scale. Cap on total annual charges for Part B and PCN services based on percent of patient's annual income, as follows:
- 5 percent for patients with incomes between 100 percent and 200 percent of FPL
  - 7 percent for patients with incomes between 200 percent and 300 percent of FPL
  - 10 percent for patients with incomes greater than 300 percent of FPL

**Performance Measure/Method:**

- Review of policy, fee schedule and cap on charges
- Review of system for tracking patient charges and payments
- Review of charges and payments to ensure that charges are discontinued once the patient has reached his/her annual cap

**Contract Manager Responsibility:**

- Review provider sliding fee scale/cap on charges policy and fee schedule to ensure that they meet legislative requirements
- Review system and records of charges and payments to ensure compliance with caps on charges
- Review client files with sliding fee application forms to ensure consistency with policies and requirements

**Provider Responsibility:** Have in place a fee discount policy that includes a cap-on-charges policy and appropriate implementation including:

- Clear responsibility for annually evaluating clients to establish individual fees and caps
- Tracking of first Part B or PCN charges or medical expenses inclusive of enrollment fees, deductible, co-payments, etc.
- A process for alerting the billing system that the client has reached the cap and should not be further charged for the remainder of the year
- Documentation of policies, fees and implementation including evidence that staff understand the policies and procedures

## V. Financial Management

1. **Standard:** Compliance by providers with all the established standards in the Code of Federal Regulations (CFR) for nonprofit organizations, hospitals, institutions of higher education and state and local governments. Included are expectations for:
- Payments for services
  - Program income
  - Revision of budget and program plans
  - Non-federal audits
  - Property standards, including the purpose of insurance coverage, equipment, supplies and other expendable property
  - Procurement standards, including recipient responsibilities, codes of conduct, competition, procurement procedures, cost and price analysis and procurement records

- Reports and records, including monitoring and reporting, program performance, financial reports and retention and access requirements
- Termination and enforcement and purpose of closeout procedures

**Performance Measure/Method:**

- Review of provider accounting systems to verify that they are sufficient and have the flexibility to operate the federal grant program and meet federal requirements
- Review of the provider systems to ensure capacity to meet requirements with regard to:
  - Payment of provider subcontractor invoices
  - Allocation of expenses of providers among multiple funding sources
- Review of provider:
  - Financial operations policies and procedures
  - Purchasing and procurement policies and procedures
  - Financial reports
- Review of provider contract and correspondence files
- Review of provider process for reallocation of funds by service category and provider

**Contract Manager Responsibility:**

- Ensure access to and review:
  - Provider accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports
  - All financial policies and procedures, including billing and collection policies and purchasing and procurement policies
- Accounts payable systems and policies
- Ensure that provider agreements require the availability of records for use by grantee auditors, staff and federal government agencies
- Include in agreements required compliance with federal standards for financial management ([45 CFR 74](#) and [94](#) or [2 CFR 215](#))
- Review provider financial systems to ensure the capacity for compliance with all federal regulations and other required reporting and make all systems and procedures accessible to federal funding and monitoring agencies

**Provider Responsibility:** Provide grantee personnel access to:

- Accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports of the provider
- All financial policies and procedures, including billing and collection policies and purchasing and procurement policies
- Accounts payable systems and policies

2. **Standard:** Comprehensive provider budgets and reports with sufficient detail to account for Part B or PCN funds by service category, provider and administrative costs and to delineate between multiple funding sources and show program income

**Performance Measure/Method:** Review of:

- Accounting policies and procedures
- Provider budgets
- Accounting system used to record expenditures using the specified allocation methodology

- Reports generated from the accounting system to determine if the detail and timeliness are sufficient to manage a Part B or PCN program

**Contract Manager Responsibility:** Determine the capacity of provider:

- Accounting policies and procedures
- Budgets
- Accounting system and reports to account for Part B or PCN funds in sufficient detail to meet program fiscal requirements

**Provider Responsibility:** Ensure adequacy of provider fiscal systems to generate needed budgets and reports, including:

- Accounting policies and procedures
- Budgets
- Accounting system and reports

**3. Standard:** Line-item provider budgets that include at least three category columns:

- Administrative
- Clinical Quality Management (CQM)
- HIV Services

**Performance Measure/Method:**

- Review of provider line-item budget and narrative for inclusion of required forms, categories and level of detail to assess the funding to be used for administration, CQM and direct provision of services and the budget's relation to the scope of services
- Review of provider line-item budget to ensure inclusion of required information and level of detail to ensure allowable use of funds and its relation to the proposed scope of services

**Contract Manager Responsibility:**

- Review line-item budget and budget justification to ensure inclusion of the following budget categories in all components of the budget:
  - Salaries and fringe benefits for program staff
  - Contractual Services - personnel or services subcontracted to outside providers, for activities not done in-house
  - Administration, capped at 10 percent
  - CQM, capped at 5 percent
- Review a Budget Justification narrative describing the uses, activities and basis for the projections of personnel costs, fringe benefits, travel, equipment, supplies, agreements and other to accompany the line-item budget

**Provider Responsibility:** Submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services

**4. Standard:** Revisions to approved budget must be approved by contract manager and/or grantee

**Performance Measure/Method:** Comparison of provider proposed operating budget to the budget approved by the contract manager and/or grantee

**Contract Manager Responsibility:**

- Receipt of a written request for the revision from the provider
- Consider the approval official only when it has been put into writing by the contract manager and received by the provider
- Include in agreements specification that budget revisions require approval and provide written instructions on the budget revision process

**Provider Responsibility:**

- Document all requests for and approvals of budget revisions

**5. Standard:** Provider agreements that meet all applicable federal and local statutes and regulations governing agreements and performance. Major areas for compliance:

- Follow state law and procedures when awarding and administering agreements (whether on a cost reimbursement or fixed amount basis)
- Ensure that every agreement includes any clauses required by federal or state statute and executive orders and their implementing regulations
- Ensure that agreements specify requirements imposed upon providers by federal or state statute and regulation
- Ensure appropriate retention of and access to records
- Ensure that any advances of grant funds to providers substantially conform to the standards of timing and amount that apply to cash advances by federal agencies

**Performance Measure/Method:** Development and review of Part B and PCN agreements to ensure compliance with local and federal requirements

**Contract Manager Responsibility:**

- Prepare provider agreements that meet both federal and local contracting requirements and provide specific clauses as stated in the standard
- Maintain file documentation of Part B or PCN provider agreements
- Revise agreements to reflect any changes in federal or state requirements
- Monitor compliance with contract provisions

**Provider Responsibility:**

- Establish policies and procedures to ensure compliance with agreement provisions
- Document and report on compliance as specified by the agreement

**VI. Property Standards****1. Standard:** Provider tracking of and reporting on tangible nonexpendable personal property, including exempt property, purchased directly with Part B or PCN funds and having:

- A useful life of more than one year, and
- An acquisition cost of \$5,000 or more per unit (lower limits may be established, consistent with grantee policies)

**Performance Measure/Method:** Review to determine that the provider has a current, complete and accurate:

- Inventory list of capital assets purchased with Part B or PCN funds

- Depreciation schedule that can be used to determine when federal revisionary interest has expired

**Contract Manager Responsibility:** Ensure that each provider maintains a current, complete and accurate asset inventory list and depreciation schedule and that they identify assets purchased with Part B or PCN funds

**Provider Responsibility:**

- Develop and maintain a current, complete and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source
- Make the list and schedule available to the grantee upon request

2. **Standard:** Implementation of adequate safeguards for all capital assets that assure that they are used solely for authorized purposes

**Performance Measure/Method:**

- Review of provider inventory lists of assets purchased with Part B or PCN funds during monitoring to ensure that assets are available and appropriately registered
- Review of depreciation schedule for capital assets for completeness and accuracy

**Contract Manager Responsibility:**

- Carry out the actions specified in VI.1
- Ensure effective control over capital assets

**Provider Responsibility:** Carry out the actions specified in VI.1

3. **Standard:** Real property, equipment, intangible property and debt instruments acquired or improved with federal funds held in trust by providers, with title of the property vested in the provider but with the federal government retaining a revisionary interest

**Performance Measure/Method:**

- Implementation of actions specified in VI.1
- Review to ensure provider policies that:
  - Acknowledge the revisionary interest of the federal government over property purchased with federal funds
  - Establish that such property may not be encumbered or disposed of without HRSA/HAB approval

**Contract Manager Responsibility:**

- Carry out the actions specified in VI.1
- Ensure policies and procedures at provider level stating that while title of property purchased with Part B funds is vested in the provider, the federal government will keep a revisionary interest
- Ensure policies at the provider level that establish that such property may not be encumbered or disposed of without the approval of HRSA/HAB as the HHS awarding agency

**Provider Responsibility:**

- Carry out the actions specified in VI.1
- Establish policies and procedures that acknowledge the revisionary interest of the federal government over property improved or purchased with federal dollars
- Maintain file documentation of these policies and procedures for grantee review

**4. Standard:** Assurance by providers that:

- Title of federally-owned property remains vested in the federal government
- If the HHS awarding agency has no further need for the property, it will be declared excess and reported to the General Services Administration

**Performance Measure/Method:** Implementation of actions specified in VI.1

**Contract Manager Responsibility:** Carry out the actions specified in VI.1

**Provider Responsibility:** Carry out the actions specified in VI.1

**5. Standard:** Title to supplies to be vested in the recipient upon acquisition, with the provision that if there is a residual inventory of unused supplies exceeding \$5,000 in total aggregate value upon termination or completion of the program and the supplies are not needed for any other federally-sponsored program, the recipient shall:

- Retain the supplies for use on non-federally sponsored activities or sell them
- Compensate the federal government for its share contributed to purchase of supplies

**Performance Measure/Method:** Review to ensure the existence of an inventory list of supplies

**Contract Manager Responsibility:** Require that providers develop and maintain current, complete and accurate supply and medication inventory lists and make them available to the grantee on request

**Provider Responsibility:**

- Develop and maintain a current, complete and accurate supply and medication inventory list
- Make the list available to the grantee upon request

**VII. Cost Principles**

**1. Standard:** Payments made to providers for services need to be cost-based and relate to Part B and PCN administrative, clinical quality management and programmatic costs in accordance with standards cited under OMB circular or Code of Federal Regulations

**Performance Measure/Method:** Review of provider budgets and expenditure reports to determine whether use of funds is consistent with OMB and CFR cost requirements

**Contract Manager Responsibility:**

- Ensure that grantee expenses conform to federal cost principles for cost-reimbursable grants
- Ensure provider staff has familiarity with [OMB-122](#) or [2 CFR 230](#) requirements
- Ensure that provider budgets and expenditures conform to OMB and CFR requirements
- Ensure agreements include a provision requiring compliance with OMB cost principles

**Provider Responsibility:**

- Ensure that budgets and expenses conform to federal cost principles
- Ensure fiscal staff familiarity with applicable federal regulations

2. **Standard:** Payments made for services to be reasonable, not exceeding costs that would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs

**Performance Measure/Method:**

- Review of provider budgets and expenditure reports to determine costs and identify cost components
- When applicable, review of unit cost calculations for reasonableness
- Review of fiscal and productivity reports to determine whether costs are reasonable when compared to level of service provided

**Contract Manager Responsibility:**

- Assess the reasonableness of provider costs by reviewing expenditures and unit cost calculations, looking with particular care at budgets and expenditure reports of provider organizations or organizational divisions that receive most of their financial support from federal or state sources
- Review and keep on file the following documentation for each provider:
  - Current budget
  - Unit cost agreement and calculation
  - Fiscal and productivity reports

**Provider Responsibility:**

- Submit reasonable and accurate budgets expenditure reports
- Make available to the grantee very detailed information on the allocation and costing out of expenses for services provided
- Calculate unit costs based on historical data
- Reconcile projected unit costs with actual unit costs on a yearly or quarterly basis

3. **Standard:** Written provider procedures for determining the reasonableness of costs, the process for allocations and the policies for allowable costs, in accordance with the provisions of applicable federal cost principles and the terms and conditions of the contract

- Costs are considered to be reasonable when they do not exceed what would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs

**Performance Measure/Method:** Review of policies and procedures that specify allowable expenditures for administrative costs and programmatic costs

- Ensure reasonableness of charges to the Part B or PCN program

**Contract Manager Responsibility:** Review to determine whether provider costs for services charged to the program are reasonable and allowable

**Provider Responsibility:**

- Have in place policies and procedures to determine allowable and reasonable costs
- Have in place reasonable methodologies for allocating costs among different funding sources and Part B or PCN categories
- Make available policies, procedures and calculations to the grantee on request

4. **Standard:** Calculation of unit costs by providers to be based on an evaluation of reasonable cost of services; financial data to relate to performance data and to include development of unit cost information whenever practical

**Note:**

- When using unit costs for the purpose of establishing fee-for-service charges, the Generally Accepted Accounting Principles (GAAP) definition can be used. Under GAAP, donated materials and services, depreciation of capital improvement, administration and facility costs are allowed when determining cost.
- If unit cost is not the method of reimbursement, it can be derived by adding direct program costs and allowable administrative costs, capped at 10 percent, and dividing by number of units of service to be delivered

**Performance Measure/Method:**

- Review of unit cost methodology for provider services
- Review of budgets to calculate allowable administrative and program costs for each service

**Contract Manager Responsibility:** Include in agreements a provision that requires submission of reports that detail performance and allow review of the provider's:

- Budget
- Cost of services
- Unit cost methodology

**Provider Responsibility:** Have in place systems that can provide expenses and client utilization data in sufficient detail to determine reasonableness of unit costs

5. **Standard:** Requirements to be met in determining the unit cost of a service:

- Unit cost not to exceed the actual cost of providing the service
- Unit cost to include only expenses that are allowable under Part B or PCN requirements

Calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided

**Performance Measure/Method:**

- Review of methodology used for calculating unit costs of services provided
- Review of budgets to calculate allowable administrative and program costs for each service

**Contract Manager Responsibility:**

- Review provider unit cost methodology
- Review provider budget components to ensure that all expense categories are allowable under Part B or PCN

**Provider Responsibility:**

- Have in place systems that can provide expenses and client utilization data in sufficient detail to calculate unit cost
- Have unit cost calculations available for grantee review

**VIII. Auditing Requirements**

- 1. Standard:** Recipients and sub-recipients of Part B funds that are institutions of higher education or other non-profit organizations (including hospitals) are subject to the audit requirements contained in the Single Audit Act Amendments of 1996 ([31 USC 7501–7507](#)) and revised [OMB Circular A-133](#), with A-133 audits required for all providers expending more than \$500,000 per year in federal grants

**Performance Measure/Method:**

- Review of requirements for provider audits
- Review of most recent audit (which may be an A-133 audit) to assure it includes:
  - List of federal grantees to ensure that the Part B grant is included
  - Programmatic income and expense reports to assess if the Part B grant is included
- Review of audit management letter if one exists
- Review of all programmatic income and expense reports for payer of last resort verification by auditor

**Contract Manager Responsibility:**

- Include in agreements a requirement for a timely annual audit and associated management letter (an A-133 audit if federal grants expended total more than \$500,000)
- Maintain file documentation of provider audits and management letters
- Review audits to ensure inclusion of Part B funding
- Review audit management letter to determine any material weaknesses
- Review audit for income and expense reports testing of payer of last resort verification

**Provider Responsibility:**

- Conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds)
- Request a management letter from the auditor
- Submit the audit and management letter to the grantee
- Prepare and provide auditor with income and expense reports that include payer of last resort verification

- 2. Standard:** Selection of auditor to be based on a defined selection (if nonprofit) policy and process

**Performance Measure/Method:** Review of provider financial policies and procedures related to audits and selection of an auditor

**Contract Manager Responsibility:**

- Ensure financial policies and procedures in place for auditor selection
- Ensure that providers have policies and procedures in place to select an auditor

**Provider Responsibility:**

- Have in place financial policies and procedures that guide selection of an auditor
- Make the policies and procedures available to grantee on request

**3. Standard:** Review of audited financial statements to verify financial stability of organization

**Performance Measure/Method:** Review of Statement of Financial Position/Balance Sheet, Statement of Activities/Income and Expense Report, Cash Flow Statement and Notes included in audit to determine organization's financial stability

**Contract Manager Responsibility:** Review provider audited financial statements and notes to determine the organization's financial status and stability

**Provider Responsibility:**

- Comply with contract audit requirements on a timely basis
- Provide audit to grantee on a timely basis

**4. Standard:** A-133 audits to include statements of conformance with financial requirements and other federal expectations

**Performance Measure/Method:** Review of statements of internal controls and federal compliance in A-133 audits

**Contract Manager Responsibility:** Annually review statements of internal controls and federal compliance in provider A-133 audits to determine compliance with federal expectations

**Provider Responsibility:**

- Comply with contract audit requirements on a timely basis
- Provide audit to grantee on a timely basis

**5. Standard:** Providers expected to note reportable conditions from the audit and provide a resolution**Performance Measure/Method:**

- Review of reportable conditions
- Determination of whether they are significant and whether they have been resolved
- Development of action plan to address reportable conditions that have not been resolved

**Contract Manager Responsibility:**

- Annually review provider audits for reportable conditions
- Obtain and review provider agency responses to audit findings
- Require corrective action if reportable conditions have not been resolved

**Provider Responsibility:**

- Comply with contract audit requirements on a timely basis
- Provide grantee the agency response to any reportable conditions

**IX. Fiscal Procedures**

- 1. Standard:** Providers have policies and procedures for handling revenues from the Part B and PCN grants, including program income

**Performance Measure/Method:**

- Review of policies and procedures related to the handling of cash or provider revenue
- Sampling of accounting entries to verify that cash and grant revenue is being recorded appropriately

**Contract Manager Responsibility:**

- Monitor policies and handling of Part B and PCN revenues by providers

**Provider Responsibility:**

- Establish policies and procedures for handling Part B and PCN revenues including program income
- Prepare a detailed chart of accounts and general ledger that provide for the tracking of Part B and PCN revenue
- Make the policies and process available for grantee review upon request

- 2. Standard:** Advances of federal funds not to exceed 30 days and to be limited to the actual, immediate cash requirements of the program

**Performance Measure/Method:**

- Review of provider agreement for allowable advances
- Review of payments to providers

**Contract Manager Responsibility:**

- Write agreements that limit advances of federal funding to 30 days
- Review documented reconciliation of federal advances to providers to submitted expenses

**Provider Responsibility:**

- Document reconciliation of advances to actual expenses

- 3. Standard:** Right of the grantee to inspect and review records and documents that detail the programmatic and financial activities of providers in the use of Part B or PCN funds

**Performance Measure/Method:** Review of provider agreements to ensure that language is included that guarantees access to records and documents as required to oversee the performance of the Part B or PCN provider

**Contract Manager Responsibility:** Include a provision in provider agreements that guarantees grantee access to provider records and documents for program and fiscal monitoring and oversight

**Provider Responsibility:** Have in place policies and procedures that allow the grantee as funding agency prompt and full access to financial, program and management records and documents as needed for program and fiscal monitoring and oversight

4. **Standard:** Grantee to have access to payroll records, tax records and invoices with supporting documentation to show that expenses were actually paid appropriately with Part B and PCN funds

**Performance Measure/Method:** Review of:

- A sample of provider payroll records
- Provider documentation that verifies that payroll taxes have been paid
- Provider accounts payable process, including a sampling of actual paid invoices with backup documentation.

**Contract Manager Responsibility:**

- Review documentation of payroll records and accounts payable and hard-copy expenditures data
- Include in agreements conditions that require the provider to maintain and provide access to primary source documentation

**Provider Responsibility:**

- Maintain documentation of payroll records and accounts payable and hard-copy expenditures data
- Make such documentation available to the grantee on request

5. **Standard:** Grantee not to withhold payments for proper charges incurred by providers unless the provider has failed to comply with agreement conditions or is indebted to the United States

**Performance Measure/Method:** Review of the timing of payments to providers through sampling that tracks accounts payable process from date invoices are received to date checks are deposited

**Contract Manager Responsibility:** Periodically track the accounts payable process from date of receipt of invoices to date the checks are deposited

**Provider Responsibility:**

- Provide timely, properly documented invoices
- Comply with contract conditions

6. **Standard:** Grantee to make payment within 30 days after receipt of a billing, unless the billing is improperly presented or lacks documentation

**Performance Measure/Method:**

- Review of grantee's payable records
- Review of provider invoices, submission dates and bank deposits of Part B and PCN payments
- Review of grantee policies on how to avoid payment delays of more than 30 days to providers

**Contract Manager Responsibility:**

- Review reimbursement to providers to determine whether it routinely occurs within 30 days of receipt of invoice and document delays due to incomplete documentation
- Take action to improve reimbursement rates if review shows payment period of more than 30 days

**Provider Responsibility:**

- Submit invoices on time monthly, with complete documentation
- Maintain data documenting reimbursement period, including monthly bank reconciliation reports and receivables aging report

**7. Standard:** Employee time and effort to be documented with charges for the salaries and wages of hourly employees:

- Be supported by documented payrolls approved by the responsible official
- Reflect the distribution of activity of each employee
- Be supported by records indicating the total number of hours worked each day

**Performance Measure/Method:** Review of documentation of employee time and effort through:

- Review of payroll records for specified employees
- Documentation of allocation of payroll between funding sources if applicable

**Contract Manager Responsibility:**

- Review payroll records for specified employees
- Review allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources

**Provider Responsibility:**

- Maintain payroll records for specified employees
- Establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources
- Make payroll records and allocation methodology available to grantee upon request

**8. Standard:** Provider fiscal staff responsible for:

- Ensuring adequate reporting, reconciliation and tracking of program expenditures
- Coordinating fiscal activities with program activities (for example, the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, formula and supplemental unobligated balances and program income)
- Have organizational and communications chart for the fiscal department

**Performance Measure/Method:**

- Review of qualifications of program and fiscal staff
- Review of program and fiscal staff plan and full-time equivalents (FTEs) to determine if there are sufficient personnel to perform the duties required of the Part B or PCN provider
- Review of provider organizational chart

**Contract Manager Responsibility:**

- Review the following:
  - Program and fiscal staff resumes and job descriptions
  - Staffing plan and provider budget and budget justification
  - Provider organizational chart
- Require and review similar information for subcontractors

**Provider Responsibility:**

- Prepare the following:
  - Program and fiscal staff resumes and job descriptions
  - Staffing plan and provider budget and budget justification
  - Provider organizational chart
- Provide information to the grantee upon request

**X. Unobligated Balances**

1. **Standard:** Provider must demonstrate its ability to expend funds efficiently by obligating and subsequently liquidating 95 percent of its Part B or PCN funds in any grant year

**Performance Measure/Method:**

- Review of provider budget
- Review of provider accounting and financial reports that document the year-to-date and year-end spending of provider obligated funds, including separate accounting for Part B formula and supplemental and PCN funds
- Calculation of unspent funds and potential unspent funds to determine estimated unobligated balance

**Contract Manager Responsibility:**

- Review provider budgets
- Review provider financial reports that document unspent funds
- Calculate year-to-date expenditures and budget variances monthly
- Review a reallocation methodology implemented in coordination with the consortia

**Provider Responsibility:**

- Report expenditures to date promptly to the grantee every month
- Inform the grantee of any situation that will make it impossible or unlikely to fully spend Part B or PCN funds

**F. HRSA Programmatic Monitoring Standards****I. Allowable Uses of Part B and PCN Service Funds**

1. **Standard:** Use of Part B and PCN funds only to support:
  - Core medical services
  - Support services that are needed by individuals with HIV/AIDS to achieve medical outcomes related to their HIV/AIDS-related clinical status
  - Clinical quality management activities
  - Planning and evaluation

**Performance Measure/Method:** Contract language that describes and defines Part B and PCN services within the range of activities and uses of funds allowed under the legislation and defined in HRSA Policy Notices including core and support services, quality management activities, administration and planning and evaluation

**Contract Manager Responsibility:** Include contract language that allows use of Part B and PCN funds only for the provision of services and activities allowed under the legislation and defined in HRSA Policy Notices

**Provider Responsibility:**

- Provide the services described in the contract
- Bill only for allowable activities
- Maintain files and share with the grantee, on request, documentation that only allowable activities are being billed to the Part B and PCN contracts

## II. Core Medical-Related Services

1. **Standard:** Provision of **Outpatient and Ambulatory Medical Care**, defined as the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room or any other type of inpatient treatment center), consistent with Public Health Service (PHS) guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies

Allowable services include:

- Diagnostic testing
- Early intervention and risk assessment
- Preventive care and screening
- Practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions
- Prescribing and managing of medication therapy
- Education and counseling on health issues
- Well-baby care
- Continuing care and management of chronic conditions
- Referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services)

**Performance Measure/Method:** Documentation of the following:

- Care is provided by health care professionals certified in their jurisdictions to prescribe medications in an outpatient setting such as a clinic, medical office or mobile van
- Only allowable services are provided
- Services are provided as part of the treatment of HIV infection and/or conditions arising from the use of HIV medications resulting in side effects
- Services are consistent with PHS guidelines
- Service is not being provided in an emergency room, hospital or any other type of inpatient treatment center

**Contract Manager Responsibility:**

- Include the definition, allowable services and limitations of outpatient ambulatory medical services in provider contracts

- Require providers to provide assurances that care is provided only in an outpatient setting, is consistent with HRSA and PHS guidelines and is chronicled in client medical records
- Review client medical records to ensure compliance with contract conditions and Ryan White program requirements
- Review the licensure of health care professionals providing ambulatory care

**Provider Responsibility:**

- Ensure that client medical records document services provided, the dates and frequency of services provided and that services are for the treatment of HIV infection
- Include clinician notes in patient records that are signed by the licensed provider of services
- Maintain professional certifications and licensure documents and make them available to the grantee on request

- 2. Standard:** As part of Outpatient and Ambulatory Medical Care, provision of **laboratory tests** integral to the treatment of HIV infection and related complications

**Performance Measure/Method:** Documentation that tests are:

- Integral to the treatment of HIV and related complications, necessary based on established clinical practice and ordered by a registered, certified, licensed provider
- Consistent with medical and laboratory standards
- Approved by the Food and Drug Administration (FDA) and/or certified under the Clinical Laboratory Improvement Amendments (CLIA) Program

**Contract Manager Responsibility:**

- Include the definition, requirements and limitations of testing in medical services contract
- Review documentation of the number of laboratory tests performed
- Review client charts to ensure requirements are met and match quantity of tests with reports

**Provider Responsibility:** Document, include in client medical records and make available to the grantee on request:

- The number of laboratory tests performed
- The certification, licenses or FDA approval of the laboratory from which tests were ordered
- The credentials of the individual ordering the tests
- Document the number of laboratory tests performed

- 3. Standard:** Implementation of a **Local AIDS Pharmaceutical Assistance Program (LPAP)** for the provision of HIV/AIDS medications using a drug distribution system that has:

- A client enrollment and eligibility process
- Uniform benefits for all enrolled clients throughout the consortium region
- A drug formulary approved by the local advisory committee/board
- A recordkeeping system for distributed medications
- A drug distribution system
- A system for drug therapy management

An LPAP that does not dispense medications as:

- A result or component of a primary medical visit
- A single occurrence of short duration (an emergency)
- Vouchers to clients on an emergency basis

An LPAP that is:

- Consistent with the most current HIV/AIDS Treatment Guidelines
- Coordinated with the state's Part B AIDS Drug Assistance Program
- Implemented in accordance with requirements of the 340B Drug Pricing Program

**Performance Measure/Method:**

- Documentation that the LPAP's drug distribution system has:
  - A client enrollment and eligibility process
  - Uniform benefits for all enrolled clients throughout the consortium region
  - A recordkeeping system for distributed medications
  - A drug distribution system that includes a drug formulary approved by the local advisory committee/board
  - A system for drug therapy management
- Documentation that the LPAP is not dispensing medications as:
  - A result or component of a primary medical visit
  - A single occurrence of short duration (an emergency) without arrangements for longer term access to medication
  - Vouchers to clients on a single occurrence without arrangements for longer-term access to medications
- Documentation that the LPAP is:
  - Consistent with the most current HIV/AIDS Treatment Guidelines
  - Coordinated with the state's Part B AIDS Drug Assistance Program
  - Implemented in accordance with requirements of 340B Drug Pricing Program

**Contract Manager Responsibility:**

- Specify in the contract language all applicable federal, state and local requirements for pharmaceutical distribution systems and the geographic area to be covered
- Ensure that the program:
  - Meets federal requirements regarding client enrollment, uniform benefits, recordkeeping and drug distribution process, consistency with current HIV/AIDS Treatment Guidelines
  - Defines the geographic area covered by the local pharmacy program, which must be either a TGA/EMA or consortium area
- Does not dispense medication as the result of a primary care visit, in emergency situations or in the form of medication vouchers to clients on a single occurrence without arrangements for longer term access to medications
- Review program records to ensure that distributed medications meet federal and contract requirements
- Review client records to ensure proper enrollment, eligibility, uniform benefits and no dispensing of medications for unallowable purposes

**Provider Responsibility:**

- Provide to the grantee, on request, documentation that the LPAP meets HRSA/HAB requirements
- Maintain documentation, and make available to the Part B grantee on request, proof of client LPAP eligibility that includes HIV status, residency, medical necessity and low-income status as defined by the consortium or state based on a specified percent of the Federal Poverty Level

- Provide reports to the Part B program of number of individuals served and the medications provided

- 4. Standard:** Support for **Oral Health Services** including diagnostic, preventive and therapeutic dental care that is in compliance with dental practice laws; includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters; is based on an oral health treatment plan; adheres to specified service caps; and is provided by licensed and certified dental professionals

**Performance Measure/Method:** Documentation that:

- Oral health services are provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and meet current dental care guidelines
- Oral health professionals providing the services have appropriate and valid licensure and certification, based on state and local laws
- An oral health treatment plan is developed for each eligible client and signed by the oral health professional rendering the services
- Services fall within specified service caps, expressed by dollar amount, type of procedure, limitations on the number of procedures, or a combination of any of the above, as determined by the grantee

**Contract Manager Responsibility:**

- Develop contracts and scopes of work for the provision of oral health that:
  - Specify allowable diagnostic, preventive and therapeutic services
  - Define and specify the limitations or caps on providing oral health services
  - Ensure that services are provided by dental professionals certified and licensed according to state guidelines
- Review client charts for compliance with contract conditions and Part B and PCN requirements such as service caps
- Review treatment plans and services for compliance with contractual and Part B and PCN programmatic requirements

**Provider Responsibility:**

- Maintain a dental chart for each client that is signed by the licensed provider and includes a treatment plan, services provided and any referrals made
- Maintain, and provide to grantee on request, copies of professional licensure and certification

- 5. Standard:** Support of **Early Intervention Services (EIS)** that include identification of individuals at points of entry and access to services and provision of:

- HIV testing and targeted counseling
- Referral services
- Linkage to care
- Health education and literacy training that enable clients to navigate the HIV system of care

All four components to be present, but Part B and PCN funds to be used for HIV testing only as necessary to supplement, not supplant, existing funding.

**Performance Measure/Method:** Documentation that:

- Part B and PCN funds are used for HIV testing only where existing federal, state and local funds are not adequate and Part B and PCN funds will supplement and not supplant existing funds for testing
- Individuals who test positive are referred for and linked to health care and supportive services
- Health education and literacy training is provided that enables clients to navigate the HIV system
- EIS is provided at or in coordination with documented key points of entry
- EIS services are coordinated with HIV prevention efforts and programs

**Contract Manager Responsibility:** Include contract language that:

- Specifies that Part B and PCN funding is to be used to supplement and not supplant existing federal, state or local funding for HIV testing
- Provides definitions and models requiring that EIS services (funded through Part B, PCN or other sources) include and are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care and education and health literacy training for clients to help them navigate the HIV care system
- Specifies that services shall be provided at specific points of entry
- Specifies required coordination with HIV prevention efforts and programs
- Requires coordination with providers of prevention services
- Requires monitoring and reporting on the number of HIV tests conducted and the number of positives found
- Requires monitoring of referrals into care and treatment
- Enables the grantee to modify targeting to include additional key points of entry

**Provider Responsibility:**

- Establish agreements with key points of entry into care to facilitate access to care for those who test positive
- Document provision of all four required EIS service components with Part B, PCN or other funding
- Document and report on numbers of HIV tests and positives, as well as where and when Part B- and PCN-funded HIV testing occurs
- Document that HIV testing activities and methods meet CDC and state requirements
- Document the number of referrals for health care and supportive services
- Document referrals from key points of entry to EIS programs
- Document training and education sessions designed to help individuals navigate and understand the HIV system of care
- Establish linkage agreements with testing sites where Part B and PCN are not funding testing but is funding referral and access to care and education, system navigation services
- Obtain written approval from the grantee to provide EIS services in points of entry not included in original scope of work

**6. Standard:** Provision of **Health Insurance Premium and Cost-sharing Assistance** that provides a cost-effective alternative to ADAP by:

- Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low-income clients that provide a full range of HIV medications

- Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of the client
- Providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs

**Performance Measure/Method:**

- Documentation of an annual cost-benefit analysis illustrating the greater benefit in purchasing public or private health insurance, pharmacy benefits, co-pays and/or deductibles for eligible low-income clients compared to the costs of having the client in the ADAP program
- Where funds are covering premiums, documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications
- Where funds are used to cover co-pays for prescription eyewear, documentation including a physician's written statement that the eye condition is related to HIV infection
- Assurance that any cost associated with the creation, capitalization or administration of a liability risk pool is not being funded by Part B or PCN
- Assurance that Part B and PCN funds are not being used to cover costs associated with Social Security
- Documentation of clients' low-income status as defined by the EMA/TGA or state Ryan White Program

**Contract Manager Responsibility:** Include contract language that:

- Specifies that Part B and PCN funding is to be used to supplement and not supplant existing federal, state or local funding for health insurance premium and cost-sharing assistance
- Ensures an annual cost-benefit analysis that includes an illustration of the greater benefit of using Part B or PCN funds for Insurance/Cost-Sharing Program versus having the client on ADAP
- Documentation of the low-income status of the client
- Where funds are used to cover the costs associated with insurance premiums, ensures that comprehensive primary care services and a full range of HIV medications are available to clients
- Provide clear directives on the payment of premiums, co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles in scopes of work and contract language
- Monitoring systems to check that funds are NOT being used for the creation, capitalization or administration of liability risk pools, social security and/or Medicare Part D costs including TrOOP or donut hole costs

**Provider Responsibility:**

- Conduct an annual cost benefit analysis (if not done by the grantee) that addresses noted criteria
- Where premiums are covered by Part B and PCN funds, provide proof that the insurance policy provides comprehensive primary care and formulary with a full range of HIV medications to clients
- Maintain proof of low-income status
- Provide documentation that demonstrates that funds were not used to cover costs associated with the creation, capitalization or administration of a liability risk pools or social security costs

- When funds are used to cover co-pays for prescription eyewear, provide a physician's written statement that the eye condition is related to HIV infection

**7. Standard:** Support for **Home Health Care** services provided in the patient's home by licensed health care workers such as nurses; services to exclude personal care and to include:

- The administration of intravenous and aerosolized treatment
- Parenteral feeding
- Diagnostic testing
- Other medical therapies

**Performance Measure/Method:** Assurance that:

- Services are limited to medical therapies in the home and exclude personal care services
- Services are provided by home health care workers with appropriate licensure as required by state and local laws

**Contract Manager Responsibility:**

- Include in the contract a clear definition of services to be provided and staffing and licensure requirements
- Review client charts to determine compliance with contract conditions and Part B and PCN program requirements
- Review licenses and certificates

**Provider Responsibility:**

- Document the number and types of services in the client records, with the provider's signature included
- Maintain on file and provide to the grantee on request copies of the licenses of home health care workers

**8. Standard:** Provision of **Home and Community-based Health Services**, defined as skilled health services furnished in the home of an HIV-infected individual, based on a written plan of care prepared by a case management team that includes appropriate health care professionals

Allowable services to include:

- Durable medical equipment
- Home health aide and personal care services
- Day treatment or other partial hospitalization services
- Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy)
- Routine diagnostic testing
- Appropriate mental health, developmental and rehabilitation services
- Specialty care and vaccinations for hepatitis co-infection provided by public and private entities

**Performance Measure/Method:**

- Documentation that:
  - All services are provided based on a written care plan signed by a case manager and a clinical health care professional responsible for the individual's HIV care and indicating the need for these services

- The care plan specifies the types of services needed and the quantity and duration of services
- All planned services are allowable within the service category
- Documentation of services provided that:
  - Specifies the types, dates and location of services
  - Includes the signature of the professional who provided the service at each visit
  - Indicates that all services are allowable under this service category
- Documentation of appropriate licensure and certifications for individuals providing the services, as required by local and state laws

#### **Contract Manager Responsibility:**

- Specify in the contracts what services are allowable, the requirement that they be provided in the home of a client with HIV/AIDS and the requirement for a written care plan signed by a case manager and a skilled health care professional responsible for the individual's HIV care
- Review program records and client files to ensure that treatment plans are prepared for all client and that they include:
  - Need for home and community-based health services
  - Types, quantity and length of time services are to be provided
- Review client files to determine:
  - Services provided, dates and locations
  - Whether services provided were allowable
  - Whether they were consistent with the treatment plan
  - Whether the file includes the signature of the professional who provided the service
- Require assurance that the service is being provided in accordance with the type of locations allowable under the definition of Home and Community-based Health Services
- Review licensure and certifications to ensure compliance with local and state laws
- Give priorities in funding to entities that will assure participation in HIV care consortia where they exist and provide the service to low-income individuals

#### **Provider Responsibility:**

- Ensure that written care plans with appropriate content and signatures are consistently prepared, included in client files and updated as needed
- Establish and maintain a program and client recordkeeping system to document the types of home services provided, dates provided, the location of the service and the signature of the professional who provided the service at each visit
- Make available to the grantee program records and client files as required for monitoring
- Provide assurance that the services are being provided only in an HIV-positive client's home
- Maintain, and make available to the grantee on request, copies of appropriate licenses and certifications for professionals providing services

- 9. Standard:** Provision of **Hospice Care** provided by licensed hospice care providers to clients in the terminal stages of illness in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice care for terminal patients

Allowable services:

- Room
- Board

- Nursing care
- Mental health counseling
- Physician services
- Palliative therapeutics

**Performance Measure/Method:**

- Documentation including the following:
  - Physician certification that the patient's illness is terminal as defined under Medicaid hospice regulations (having a life expectancy of 6 months or less)
  - Appropriate and valid licensure of provider as required by the state in which hospice care is delivered
  - Types of services provided and assurance that they include only allowable services
  - Locations where hospice services are provided and assurance that they are limited to a home or other residential setting or a non-acute care section of a hospital designated and staffed as a hospice setting
- Assurance that services meet Medicaid or other applicable requirements, including the following:
  - Counseling services that are consistent with the definition of mental health counseling, including treatment and counseling provided by mental health professionals (psychiatrists, psychologists or licensed clinical social workers) who are licensed or authorized within the state where the service is provided
  - Palliative therapies that are consistent with those covered under the respective state's Medicaid program

**Contract Manager Responsibility:**

- Specify in contracts allowable services, service standards, service locations and licensure requirements
- Review provider licensure to ensure it meets requirements of state in which hospice care is delivered
- Review program records and client files to ensure the following:
  - Physician certification of client's terminal status
  - Documentation that services provided are allowable and funded hospice activities
  - Assurance that hospice services are provided in permitted settings
  - Assurance that services such as counseling and palliative therapies meet Medicaid or other applicable requirements

**Provider Responsibility:**

- Obtain and have available for inspection appropriate and valid licensure to provide hospice care
- Maintain and provide the grantee access to program records and client files that include documentation of:
  - Physician certification of client's terminal status
  - Services provided and that they are allowable under Part B and PCN and in accordance with the provider contract and scope of work
  - Locations where hospice services are provided include only permitted settings
  - Services such as counseling and palliative therapies meet Medicaid or other applicable requirements as specified in the contract

**10. Standard:** Funding of **Mental Health Services** that include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness; conducted in a group or individual setting; based on a detailed treatment plan; and provided by a mental health professional licensed or authorized within the state to provide such services, typically including psychiatrists, psychologists and licensed clinical social workers

**Performance Measure/Method:**

- Documentation of appropriate and valid licensure and certification of mental health professionals as required by the state
- Documentation of the existence of a detailed treatment plan for each eligible client that includes:
  - The diagnosed mental illness or condition
  - The treatment modality (group or individual)
  - Start date for mental health services
  - Recommended number of sessions
  - Date for reassessment
  - Projected treatment end date
  - Any recommendations for follow up
  - The signature of the mental health professional rendering service
- Documentation of service provided to ensure that:
  - Services provided are allowable under Part B and PCN guidelines and contract requirements
  - Services provided are consistent with the treatment plan

**Contract Manager Responsibility:**

- Specify in contracts allowable services and treatment modalities, staffing and licensure requirements and requirements for treatment plans and service documentation
- Review staffing and the licenses and certification of mental health professionals to ensure compliance with Part B, PCN and state requirements
- Review program reports and client charts to:
  - Ensure the existence of a treatment plan that includes required components and signature
  - Document services provided, dates and their consistency with Part B and PCN requirements and with the treatment plan

**Provider Responsibility:**

- Obtain and have on file and available for grantee review appropriate and valid licensure and certification of mental health professionals
- Maintain program records documenting services provided
- Maintain client charts that include:
  - A detailed treatment plan for each eligible client that includes required components and signature
  - Documentation of services provided, dates and consistency with Part B and PCN requirements and with individual client treatment plans

**11. Standard:** Support for **Medical Nutrition Therapy** services including nutritional supplements provided outside of a primary care visit by a licensed registered dietitian; may include food provided pursuant to a physician's recommendation and based on a nutritional plan developed by a licensed registered dietitian

**Performance Measure/Method:** Documentation of:

- Licensure and registration of the dietitian as required by the state in which the service is provided
- Where food is provided to a client under this service category, client file that includes a physician's recommendation and a nutritional plan
- Required content of the nutritional plan, including:
  - Recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food
  - Date service is to be initiated
  - Planned number and frequency of sessions
  - The signature of the registered dietitian who developed the plan
- Services provided, including:
  - Nutritional supplements and food provided, quantity and dates
  - The signature of each registered dietitian who rendered service, the date of service
  - Date of reassessment
  - Termination date of medical nutrition therapy
  - Any recommendations for follow up

**Contract Manager Responsibility:**

- Specify in contracts:
  - The allowable services to be provided
  - The requirement for provision of services by a licensed registered dietitian
  - The requirement for a nutritional plan and physician's recommendation where food is provided through this service category
  - The required content of the nutritional plan
- Review program records and client files for:
  - Documentation of the licensure and registration of the dietitian providing services
  - Documentation of services provided, including the quantity and number of recipients of nutritional supplements and food
  - Documentation of physician recommendations and nutritional plans for clients provided food
  - Content of the nutritional plan
- Documentation of medical nutritional therapy services provided to each client, compliance with Part B and PCN and contract requirements and consistency of services with the nutritional plan

**Provider Responsibility:**

- Maintain and make available to the grantee copies of the dietitian's license and registration
- Document services provided, number of clients and quantity of nutritional supplements and food provided to clients
- Document in each client file:
  - Services provided and dates
  - Nutritional plan as required, including required information and signature
  - Physician's recommendation for the provision of food

**12. Standard:** Support for **Medical Case Management Services** (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services

and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact and any other form of communication

Activities that include at least the following:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Coordination of services required to implement the plan
- Continuous client monitoring to assess the efficacy of the plan
- Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary

Service components that may include:

- A range of client-centered services that link clients with health care, psychosocial and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, state pharmacy assistance programs, pharmaceutical manufacturers' patient assistance programs and other state or local health care and supportive services)
- Coordination and follow up of medical treatments
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments
- Client-specific advocacy and/or review of utilization of services

**Performance Measure/Method:**

- Documentation that service providers are trained professionals, either medically credentialed persons or other health care staff who are part of the clinical care team
- Documentation that all the following activities are being carried out for all clients:
  - Initial assessment of service needs
  - Development of a comprehensive, individualized care plan
  - Coordination of services required to implement the plan
  - Continuous client monitoring to assess the efficacy of the plan
  - Periodic re-evaluation and adaptation of the plan, at least every 6 months, during the enrollment of the client
- Documentation in program and client records of case management services and encounters, including:
  - Types of services provided
  - Types of encounters/communication
  - Duration and frequency of the encounters
- Documentation in client records of services provided, such as:
  - Client-centered services that link clients with health care, psychosocial and other services and assist them to access other public and private programs for which they may be eligible
  - Coordination and follow up of medical treatments
  - Ongoing assessment of client's and other key family members' needs and personal support systems
  - Treatment adherence counseling

- Client-specific advocacy

**Contract Manager Responsibility:**

- Develop contracts that:
  - Clearly define medical case management services and activities and specify required activities and components
  - Specify required documentation to be included in client charts
- Review client files and service documentation to ensure compliance with contractual and Part B and PCN programmatic requirements, including inclusion of required case management activities
- Review medical credentials and/or evidence of training of health care staff providing medical case management services
- Obtain assurances and documentation showing that medical case management staff are operating as part of the clinical care team

**Provider Responsibility:**

- Provide written assurances and maintain documentation showing that medical case management services are provided by trained professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team
- Maintain client charts that include the required elements for compliance with contractual and Part B and PCN programmatic requirements, including required case management activities such as services and activities, the type of contact and the duration and frequency of the encounter

**13. Standard:** Support for **Substance Abuse Treatment Services - Outpatient**, provided by or under the supervision of a physician or other qualified/licensed personnel; may include use of funds to expand HIV-specific capacity of programs if timely access to treatment and counseling is not otherwise available

Services limited to the following:

- Pre-treatment/recovery readiness programs
- Harm reduction
- Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse
- Outpatient drug-free treatment and counseling
- Opiate Assisted Therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Limited acupuncture services with a written referral from the client's primary health care provider, provided by certified or licensed practitioners wherever state certification or licensure exists
- Services provided must include a treatment plan that calls only for allowable activities and includes:
  - The quantity, frequency and modality of treatment provided
  - The date treatment begins and ends
  - Regular monitoring and assessment of client progress
  - The signature of the individual providing the service and or the supervisor as applicable

**Performance Measure/Method:**

- Documentation that services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the state in which services are provided
- Documentation through program records and client files that:
  - Services provided meet the service category definition
  - All services provided are allowable under Part B and PCN
- Assurance that services are provided only in an outpatient setting
- Assurance that Part B and PCN funds are used to expand HIV-specific capacity of programs only if timely access would not otherwise be available to treatment and counseling
- Assurance that services provided include a treatment plan that calls for only allowable activities and includes:
  - The quantity, frequency and modality of treatment provided
  - The date treatment begins and ends
  - Regular monitoring and assessment of client progress
  - The signature of the individual providing the service and or the supervisor as applicable
- Documentation that
  - The use of funds for acupuncture services is limited through some form of defined cap
  - Acupuncture is not the dominant treatment modality
  - Acupuncture services are provided only with a written referral from the client's primary care provider
  - The acupuncture provider has appropriate state license and certification

**Contract Manager Responsibility:**

- Develop contracts that clearly specify:
  - Allowable activities under this service category
  - The requirement that services be provided on an outpatient basis
  - The information that must be documented in each client's file
- Review staff licensure and certification and staffing structure to ensure that services are provided under the supervision of a physician or other qualified/licensed personnel
- Require assurance that services are provided on an outpatient basis
- Review program records and client files for evidence of a treatment plan that specifies only allowable activities and includes:
  - The quantity, frequency and modality of treatment provided
  - The date treatment begins and ends
  - Regular monitoring and assessment of client progress
  - The signature of the individual providing the service and or the supervisor as applicable
- For any client receiving acupuncture services under this service category, documentation in the client file including:
  - Caps on use of Part B and PCN funds are in place
  - A written referral from their primary health care provider
  - Proof that the acupuncturist has appropriate certification or licensure, if the state provides such certification or licensure

**Provider Responsibility:**

- Maintain and provide to grantee on request documentation of:

- Provider licensure or certifications as required by the state in which service is provided; this includes licensures and certifications for a provider of acupuncture services
- Staffing structure showing supervision by a physician or other qualified personnel
- Provide assurance that all services are provided on an outpatient basis
- Maintain program records and client files that include treatment plans with all required elements and document:
  - That all services provided are allowable under PCN
  - The quantity, frequency and modality of treatment services
  - The date treatment begins and ends
  - Regular monitoring and assessment of client progress
  - The signature of the individual providing the service or the supervisor as applicable
- In cases where acupuncture therapy services are provided, document in the client file:
  - A written referral from the primary health care provider
  - The quantity of acupuncture services provided
  - The cap on such services

### III. Support Services

- 1. Standard:** Use of Part B and PCN funds only for Support Services approved by the Secretary of Health and Human Services or approved by the HIV/AIDS and Hepatitis Program (PCN funds only)

**Performance Measure/Method:** Documentation that all funded support services are on the current list of HHS-approved support services or HIV/AIDS and Hepatitis Program-approved (PCN funds only)

**Contract Manager Responsibility:**

- Contract for only HHS-approved or HIV/AIDS and Hepatitis Program-approved (PCN funds only) support services
- Monitor providers to ensure that no Part B and PCN funds are used for non-allowable services categories

**Provider Responsibility:**

- Provide assurance to the grantee that Part B and PCN funds are being used only for support services approved by HHS or approved by the HIV/AIDS and Hepatitis Program (PCN funds only)

- 2. Standard:** Support for **Case Management (Non-medical)** services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial and other needed services

May include:

- Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible
- All types of case management encounters and communications (face-to-face, telephone contact, other)
- Transitional case management for incarcerated persons as they prepare to exit the correctional system

*Note:* Does not involve coordination and follow up of medical treatments

**Performance Measure/Method:**

- Documentation that:
  - Scope of activity includes advice and assistance to clients in obtaining medical, social, community, legal, financial and other needed services
  - Where benefits/entitlement counseling and referral services are provided, they assist clients in obtaining access to both public and private programs, such as Medicaid, Medicare Part D, state pharmacy assistance programs, pharmaceutical manufacturers' patient assistance programs and other state or local health care and supportive services
  - Services cover all types of encounters and communications (e.g., face-to-face, telephone contact, other)
- Where transitional case management for incarcerated persons is provided, assurance that such services are provided either as part of discharge planning or for individuals who are in the correctional system for a brief period

**Contract Manager Responsibility:**

- Include in contracts and scopes of work:
  - Clear statement of required and optional case management services and activities, including benefits/entitlement counseling
  - Full range of allowable types of encounters and communications
- Require in contract that client charts document at least the following:
  - Date of each encounter
  - Type of encounter (e.g., face-to-face, telephone contact, etc.)
  - Duration of encounter
  - Key activities
- Review client files and service documentation for compliance with contract requirements

**Provider Responsibility:**

- Maintain client charts that include the required elements as detailed by the grantee, including:
  - Date of encounter
  - Type of encounter
  - Duration of encounter
  - Key activities, including benefits/entitlement counseling and referral services
- Provide assurances that any transitional case management for incarcerated persons meets contract requirements

- 3. Standard:** Funding for **Child Care Services** for the children of HIV-positive clients, provided intermittently, only while the client attends medical or other appointments or Part B- and PCN-related meetings, groups or training sessions

May include use of funds to support:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Such allocations to be limited and carefully monitored to assure:

- Compliance with the prohibition on direct payments to eligible individuals
- Assurance that liability issues for the funding source are carefully weighed and addressed through the use of liability release forms designed to protect the client, provider and the Part B and PCN programs

May include **Recreational and Social Activities** for the child, if provided in a licensed or certified provider setting including drop-in centers in primary care or satellite facilities

- Excludes use of funds for off-premise social/recreational activities

**Performance Measure/Method:**

- Documentation of:
  - The parent's eligibility as defined by the grantee, including proof of HIV status
  - The medical or other appointments or Part B and PCN program-related meetings, groups or training sessions attended by the parent that made child care services necessary
  - Appropriate and valid licensure and registration of child care providers under applicable state and local laws in cases where the services are provided in a day care or child care setting
- Assurance that
  - Where child care is provided by a neighbor, family member or other person, payments do not include cash payments to clients or primary caregivers for these services
  - Liability issues for the funding source are addressed through use of liability release forms designed to protect the client, provider and the Part B and PCN programs
  - Any recreational and social activities are provided only in a licensed or certified provider setting

**Contract Manager Responsibility:**

- Develop contracts and scopes of work as appropriate that clearly define child care services and allowable settings
- Provide documentation that demonstrates that the grantee has clearly addressed the limitations of informal child care arrangements, including the issues of liability raised by such informal arrangements in child care and the appropriate and legal releases from liability that cover the Part B and PCN program and other federal, state and local entities as allowed by law
- Require provider documentation that records the frequency, dates and length of service and type of medical or other appointment or Part B- and PCN-related meeting, group or training session that made child care necessary
- Review provider documentation to ensure that child care is intermittent and is provided only to permit the client to keep medical and other appointments or other permitted Part B or PCN-related activities
- Develop a mechanism for use with informal child care arrangements to ensure that no direct cash payments are made to clients or primary caregivers
- Document that any recreational and social activities are provided only within a licensed or certified provider setting

**Provider Responsibility:**

- Maintain documentation of:
  - Date and duration of each unit of child care service provided
  - Eligibility of client (HIV status, residence and income eligibility)

- Reason why child care was needed – e.g., client medical or other appointment or participation in a Part B- and PCN-related meeting, group or training session
- Any recreational and social activities, including documentation that they were provided only within a certified or licensed provider setting
- Where provider is a child care center or program, make available for inspection appropriate and valid licensure or registration as required under applicable state and local laws
- Where the provider manages informal child care arrangements, maintain and have available for grantee review:
  - Documentation of compliance with grantee-required mechanism for handling payments for informal child care arrangements
  - Appropriate liability release forms obtained that protect the client, provider and the Part B and PCN programs
  - Documentation that no cash payments are being made to clients or primary care givers
  - Documentation that payment is for actual costs of service

- 4. Standard:** Support for **Emergency Financial Assistance (EFA)** for essential services, including utilities, housing, food (including groceries, food vouchers and food stamps) or medications, provided to clients with limited frequency and for limited periods of time, through either:
- Short-term payments to agencies
  - Establishment of voucher programs

**Note:** Direct cash payments to clients are not permitted

**Performance Measure/Method:** Documentation of services and payments to verify that:

- EFA to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the grantee
- Assistance is provided only for the following essential services: utilities, housing, food (including groceries, food vouchers and Food Stamps) or medications
- Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to clients
- Emergency funds are allocated, tracked and reported by type of assistance
- Part B and PCN are the payers of last resort

**Contract Manager Responsibility:**

- Develop contracts that:
  - Define the allowable uses of EFA funds and the limitations of the program, including number/level of payments permitted to a single client
  - Require that Part B and PCN funds are used for EFA only as a last resort
  - Require providers to record and track use of EFA funds under each discrete service category as required by the Ryan White Services Report (RSR) and Ryan White Data Report (RDR) (Part B only)
- Review provider services and payment documentation to assure compliance with contractual and Part B and PCN programmatic requirements including:
  - Uses of funds
  - Methods of providing EFA payments
  - Use of Part B and PCN as payers of last resort
  - Specified limits on amounts and frequency of EFA to a single client

**Provider Responsibility:**

- Maintain client records that document for each client:
  - Client eligibility and need for EFA
  - Types of EFA provided
  - Date(s) EFA was provided
  - Method of providing EFA
- Maintain and make available to the grantee program documentation of assistance provided, including:
  - Number of clients and amount expended for each type of EFA
  - Summary of number of EFA services received by client
  - Methods used to provide EFA (e.g., payments to agencies, vouchers)
- Provide assurance to the grantee that all EFA:
  - Was for allowable types of assistance
  - Was used only in cases where Part B or PCN was the payer of last resort
  - Met grantee-specified limitations on amount and frequency of assistance to an individual client
  - Was provided through allowable payment methods

**5. Standard: Funding for Food Bank/Home-delivered Meals** that may include:

- The provision of actual food items
- Provision of hot meals
- A voucher program to purchase food

May also include the provision of non-food items that are limited to:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues with water purity exist

Appropriate licensure/certification for food banks and home delivered meals where required under state or local regulations

No funds used for:

- Permanent water filtration systems for water entering the house
- Household appliances
- Pet foods
- Other non-essential products

**Performance Measure/Method:**

- Documentation that:
  - Services supported are limited to food bank, home-delivered meals and/or food voucher program
  - Types of non-food items provided are allowable
  - If water filtration/purification systems are provided, community has water purity issues
- Assurance of:
  - Compliance with federal regulations
  - Compliance with state and local regulations including any required licensure or certification for the provision of food banks and/or home-delivered meals

- Use of funds only for allowable essential non-food items
- Monitoring of providers to document actual services provided, client eligibility, number of clients served and level of services to these clients

**Contract Manager Responsibility:**

- Develop contracts that specify:
  - What types of services are to be supported – food bank, home-delivered meals and/or food voucher program
  - Allowable and prohibited uses of funds for non-food items
  - Requirements for documenting services provided, client eligibility and level and type of services provided to clients
- Monitor providers to ensure:
  - Compliance with contractual requirements and with other federal, state and local laws and regulations regarding food banks, home-delivered meals and food voucher programs, including any required licensure and/or certifications
  - Verification that Part B and PCN funds are used only for purchase of allowable non-food items

**Provider Responsibility:**

- Maintain and make available to grantee documentation of:
  - Services provided by type of service, number of clients served and levels of service
  - Amount and use of funds for purchase of non-food items, including use of funds only for allowable non-food items
  - Compliance with all federal, state and local laws regarding the provision of food bank, home-delivered meals and food voucher programs, including any required licensure and/or certifications
- Provide assurance that Part B and PCN funds were used only for allowable purposes and Part B and PCN were the payers of last resort

**6. Standard:** Support for **Health Education/Risk Reduction** services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission

Includes:

- Provision of information about available medical and psychosocial support services
- Education on HIV transmission and how to reduce the risk of transmission
- Counseling on how to improve their health status and reduce the risk of HIV transmission to others

**Performance Measure/Method:** Documentation that clients served under this category:

- Are educated about HIV transmission and how to reduce the risk of HIV transmission to others
- Receive information about available medical and psychosocial support services
- Receive education on methods of HIV transmission and how to reduce the risk of transmission
- Receive counseling on how to improve their health status and reduce the risk of transmission to others

**Contract Manager Responsibility:**

- Develop contracts that define risk reduction counseling and provide guidance on the types of information, education and counseling to be provided to the client
- Review provider data to:
  - Determine compliance with contract and program obligations
  - Ensure that clients have been educated and counseled on HIV transmission and risk reduction
  - Ensure that clients have been provided information about available medical and psychosocial support services

**Provider Responsibility:**

- Maintain, and make available to the grantee on request, records of services provided
- Document in client charts:
  - Client eligibility
  - Information provided on available medical and psychosocial support services
  - Education about HIV transmission
  - Counseling on how to improve their health status and reduce the risk of HIV transmission

7. **Standard:** Support for **Housing Services** that involve the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care

Use of funds for:

- Housing that provides some type of medical or supportive services such as residential mental health services, foster care or assisted living residential services
- Housing that does not provide direct medical or supportive services
- Housing-related referral services that include assessment, search, placement, advocacy and the fees associated with them

No use of funds for direct payments to recipients of services for rent or mortgages

**Note:** A 24-month cumulative cap on short-term and emergency housing assistance has been rescinded pending completion of a comprehensive review of HRSA/HAB housing policy

**Performance Measure/Method:**

- Documentation that funds are used only for allowable purposes:
  - The provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care
  - Housing-related referral services including housing assessment, search, placement, advocacy and the fees associated with them
  - Housing that includes some type of medical or supportive services
  - Housing that does not include such services
- Documentation that:
  - Each client receives assistance designed to help him/her obtain stable long-term housing through a strategy to identify, re-locate and/or ensure the individual or family is moved to or capable of maintaining a stable long-term living situation
  - No funds are used for direct payments to recipients of services for rent or mortgages

**Contract Manager Responsibility:**

- Develop contracts that clearly define and specify allowable housing-related services, including housing-related referrals, types of housing and focus on short-term housing assistance
- Review and monitor provider programs to:
  - Determine compliance with contract and program requirements
  - Ensure that housing referral services include housing assessment, search, placement, advocacy and the fees associated with them
  - Ensure that clients receive assistance in obtaining stable long-term housing
  - Verify that no Part B or PCN funds are used for direct payment to clients for rent or mortgages

**Provider Responsibility:**

- Document:
  - Services provided including number of clients served, duration of housing services, types of housing provided and housing referral services
- Maintain client records that document:
  - Client eligibility
  - Housing services, including referral services provided
  - Assistance provided to clients to help them obtain stable long-term housing
- Provide documentation and assurance that no Part B or PCN funds are used to provide direct payments to clients for rent or mortgages

- 8. Standard:** Funding for **Legal Services** provided for an HIV-infected person to address legal matters directly necessitated by the individual's HIV status

May include such services as (but not limited to):

- Preparation of Powers of Attorney and Living Wills
- Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under Part B and PCN

Permanency planning for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS; includes the provision of social service counseling or legal counsel regarding (1) the drafting of wills or delegating powers of attorney or (2) preparation for custody options for legal dependents including standby guardianship, joint custody or adoption

Excludes:

- Criminal defense
- Class-action suits unless related to access to services eligible for funding under the Part B and PCN programs

**Performance Measure/Method:**

- Documentation that funds are used only for allowable legal services, which involve legal matters directly necessitated by an individual's HIV status, such as:
  - Preparation of Powers of Attorney and Living Wills
  - Services designed to ensure access to eligible benefits

- Assurance that program activities do not include any criminal defense or class-action suits unrelated to access to services eligible for funding under the Part B and PCN programs

**Contract Manager Responsibility:**

- Develop contracts that clearly define allowable and non-allowable legal services and state the requirement that services must address legal matters directly necessitated by the individual's HIV status
- Monitor providers to ensure that:
  - Funds are being used only for allowable services
  - No funds are being used for criminal defense or for class-action suits unless related to access to services eligible for funding under the Part B and PCN programs

**Provider Responsibility:**

- Document, and make available to the grantee upon request, services provided, including specific types of legal services provided
- Provide assurance that:
  - Funds are being used only for legal services directly necessitated by an individual's HIV status
  - Part B and PCN serve as the payers of last resort
- Document in each client file:
  - Client eligibility
  - A description of how the legal service is necessitated by the individual's HIV status
  - Types of services provided
  - Hours spent in the provision of such services

9. **Standard:** Support for **Linguistic Services** including interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of Part B- and PCN-eligible services

**Performance Measure/Method:**

- Documentation that:
  - Linguistic services are being provided as a component of HIV service delivery between the provider and the client, to facilitate communication between the client and provider and the delivery of Part B- and PCN-eligible services in both group and individual settings
  - Services are provided by appropriately trained and qualified individuals holding appropriate state or local certification

**Contract Manager Responsibility:**

- Develop contract and scope of work that clearly describe:
  - The range and types of linguistic services to be provided, including oral interpretation and written translation as needed to facilitate communications and service delivery
  - Requirements for training and qualifications based on available state and local certification
- Monitor providers to assure that:
  - Linguistic services are provided based on documented provider need in order for Part B and PCN clients to communicate with the provider and/or receive appropriate services

- Interpreters and translators have appropriate training and state or local certification

**Provider Responsibility:**

- Document the provision of linguistic services, including:
  - Number and types of providers requesting and receiving services
  - Number of assignments
  - Languages involved
  - Types of services provided – oral interpretation or written translation and whether interpretation is for an individual client or a group
- Maintain documentation showing that interpreters and translators employed with Part B or PCN funds have appropriate training and hold relevant state and/or local certification

**10. Standard:** Funding for **Medical Transportation Services** that enable an eligible individual to access HIV-related health and support services, including services needed to maintain the client in HIV medical care, through either direct transportation services or vouchers or tokens

May be provided through:

- Contracts with providers of transportation services
- Voucher or token systems
- Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Purchase or lease of organizational vehicles for client transportation programs, provided the grantee receives prior approval for the purchase of a vehicle

**Performance Measure/Method:**

- Documentation that: medical transportation services are used only to enable an eligible individual to access HIV-related health and support services
- Documentation that services are provided through one of the following methods:
  - A contract or some other local procurement mechanism with a provider of transportation services
  - A voucher or token system that allows for tracking the distribution of the vouchers or tokens
  - A system of mileage reimbursement that does not exceed the federal per-mile reimbursement rates
  - A system of volunteer drivers, where insurance and other liability issues are addressed
  - Purchase or lease of organizational vehicles for client transportation, with prior approval from HRSA/HAB for the purchase

**Contract Manager Responsibility:**

- Develop contracts that:
  - Clearly define medical transportation in terms of allowable services and methods of delivery
  - Require record keeping that tracks both services provided and the purpose of the service (e.g., transportation to/from what type of medical or support service appointment)
  - Specify requirements related to each service delivery method
  - Require that clients receive vouchers or tokens rather than direct payments for transportation services

- Monitor providers to ensure that use of funds meets contract and program requirements

**Provider Responsibility:**

- Maintain program records that document:
  - The level of services/number of trips provided
  - The reason for each trip and its relation to accessing health and support services
  - Trip origin and destination
  - Client eligibility
  - The cost per trip
  - The method used to meet the transportation need
- Maintain documentation showing that the provider is meeting stated contract requirements with regard to methods of providing transportation:
  - Reimbursement methods do not involve cash payments to service recipients
  - Mileage reimbursement does not exceed the federal reimbursement rate
  - Use of volunteer drivers appropriately addresses insurance and other liability issues
- Collection and maintenance of data documenting that funds are used only for transportation designed to help eligible individuals remain in medical care by enabling them to access medical and support services

**11. Standard:** Support for **Outreach Services** designed to identify individuals who do not know their HIV status and/or individuals who know their status and are not in care and help them to learn their status and enter care

Outreach programs must be:

- Planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort
- Targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection
- Targeted to communities or local establishments that are frequented by individuals exhibiting high-risk behavior
- Conducted at times and in places where there is a high probability that individuals with HIV infection will be reached
- Designed to provide quantified program reporting of activities and results to accommodate local evaluation of effectiveness

**Note:** Funds may not be used to pay for HIV counseling or testing

**Performance Measure/Method:**

- Documentation that outreach services are designed to identify:
  - Individuals who do not know their HIV status and refer them for counseling and testing
  - Individuals who know their status and are not in care and help them enter or re-enter HIV-related medical care
- Documentation that outreach services:
  - Are planned and delivered in coordination with local HIV prevention outreach programs and avoid duplication of effort
  - Target populations known to be at disproportionate risk for HIV infection

- Target communities whose residents have disproportionate risk or establishments frequented by individuals exhibiting high-risk behaviors
- Are designed so that activities and results can be quantified for program reporting and evaluation of effectiveness
- Documentation and assurance that outreach funds are not being used:
  - For HIV counseling and testing
  - To support broad-scope awareness activities that target the general public rather than specific populations and/or communities with high rates of HIV infection
  - To duplicate HIV prevention outreach efforts

**Contract Manager Responsibility:**

- Develop contracts that:
  - Provide a detailed description of the required scope and components of an outreach program, including whether it targets individuals who know and/or who do not know their HIV status
  - Specify parameters to ensure that the program meets all HRSA/HAB requirements and guidance
  - Require clearly defined targeting of populations and communities
  - Require quantified reporting of individuals reached, referred for testing, found to be positive, referred to care and entering care, to facilitate evaluation of effectiveness
- Provide program monitoring and review for compliance with contract and program requirements and to ensure that funds are not being used:
  - For HIV counseling and testing
  - To support broad-scope awareness activities
  - To duplicate HIV prevention outreach efforts

**Provider Responsibility:**

- Document and be prepared to share with the grantee:
  - The design, implementation, target areas and populations and outcomes of outreach activities, including the number of individuals reached, referred for testing, found to be positive, referred to care and entering care
  - Data showing that all contract requirements are being met with regard to program design, targeting, activities and use of funds
- Provide financial and program data demonstrating that no outreach funds are being used:
  - To pay for HIV counseling and testing
  - To support broad-scope awareness activities
  - To duplicate HIV prevention outreach efforts

**12. Standard: Support for Psychosocial Support Services** that may include:

- Support and counseling activities
- Child abuse and neglect counseling
- HIV support groups
- Pastoral care/counseling
- Caregiver support
- Bereavement counseling
- Nutrition counseling provided by a non-registered dietitian

**Note:** Funds under this service category may not be used to provide nutritional supplements

**Pastoral care/counseling** supported under this service category to be:

- Provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider)
- Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available
- Available to all individuals eligible to receive Part B and PCN services, regardless of their religious denominational affiliation

**Performance Measure/Method:**

- Documentation that psychosocial services funds are used only to support eligible activities, including:
  - Support and counseling activities
  - Child abuse and neglect counseling
  - HIV support groups
  - Pastoral care/counseling
  - Caregiver support
  - Bereavement counseling
  - Nutrition counseling provided by a non-registered dietitian
- Documentation that pastoral care/counseling services meet all stated requirements:
  - Provided by an institutional pastoral care program
  - Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available
  - Available to all individuals eligible to receive Part B and PCN services, regardless of their religious denominational affiliation
  - Assurance that no funds under this service category are used for the provision of nutritional supplements

**Contract Manager Responsibility:**

- Develop contracts that clearly specify:
  - The range and limitations of allowable services
  - Types of permitted pastoral care/counseling
- Monitor providers to ensure compliance with contract and program requirements
- Provide assurance that:
  - Funds are being used only for allowable services
  - No funds are being used for the provision of nutritional supplements
  - Funds for pastoral care/counseling meet all stated requirements regarding the program, provider licensing or accreditation and availability to all clients regardless of religious affiliation

**Provider Responsibility:**

- Document the provision of psychosocial support services, including:
  - Types and level of activities provided
  - Client eligibility
- Maintain documentation demonstrating that:

- Funds are used only for allowable services
- No funds are used for provision of nutritional supplements
- Any pastoral care/counseling services meet all stated requirements

**13. Standard:** Support for **Referral for Health Care/Supportive Services** that direct a client to a service in person or through telephone, written or other types of communication, including the management of such services where they are not provided as part of Ambulatory/Outpatient Medical Care or Case Management services

May include benefits/entitlement counseling and referral to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, state pharmacy assistance programs, pharmaceutical manufacturers' patient assistance programs and other state or local health care and supportive services

Referrals may be made:

- Within the Non-medical Case Management system by professional case managers
- Informally through community health workers or support staff
- As part of an outreach program

**Performance Measure/Method:**

- Documentation that funds are used only:
  - To direct a client to a service in person or through other types of communication
  - To provide benefits/entitlements counseling and referral consistent with HRSA requirements
  - To manage such activities
  - Where these services are not provided as a part of Ambulatory/Outpatient Medical Care or Case Management services
- Documentation of:
  - Method of client contact/communication
  - Method of providing referrals (within the Non-medical Case Management system, informally or as part of an outreach program)
  - Referrals and follow up provided

**Contract Manager Responsibility:**

- Develop contracts to:
  - Clearly specify allowable activities and methods of communication
  - Specify that services may include benefits/entitlements counseling and referral and provide a definition and description of these services
  - Clearly define the circumstances under which these activities may take place in order to avoid duplication with referrals provided through other service categories such as Non-medical Case Management
  - Require documentation of referrals and follow up
- Monitor providers to ensure compliance with contract and program requirements
- Provide assurance that funds are not being used to duplicate referral services provided through other service categories

**Provider Responsibility:**

- Maintain program records that document:

- Number and types of referrals provided
- Benefits counseling and referral activities
- Number of clients served
- Follow up provided
- Maintain client charts that include required elements as detailed by the grantee, including:
  - Date of service
  - Type of communication
  - Type of referral
  - Benefits counseling/referral provided
  - Follow up provided
- Maintain documentation demonstrating that services and circumstances of referral services meet contract requirements

**14. Standard:** Funding for **Rehabilitation Services:** Services intended to improve or maintain a client's quality of life and optimal capacity for self-care, provided by a licensed or authorized professional in an outpatient setting in accordance with an individualized plan of care

May include:

- Physical and occupational therapy
- Speech pathology services
- Low-vision training

**Performance Measure/Method:**

- Documentation that services:
  - Are intended to improve or maintain a client's quality of life and optimal capacity for self-care
  - Are limited to allowable activities, including physical and occupational therapy, speech pathology services and low-vision training
  - Are provided by a licensed or authorized professional
  - Are provided in accordance with an individualized plan of care that includes components specified by the grantee

**Contract Manager Responsibility:**

- Develop contracts that:
  - Clearly define rehabilitation services and allowable activities
  - Specify requirement for provision of services by a licensed or authorized professional in accordance with an individualized plan of care
  - Specify where these activities may take place in order to avoid their provision in in-patient settings
- Monitor providers to ensure compliance with contract and program requirements
- Review program and client records to ensure that:
  - Client has a individualized plan of care that includes specified components
  - Services provided are in accordance with the plan of care

**Provider Responsibility:**

- Maintain, and share with the grantee upon request, program and financial records that document:

- Types of services provided
- Type of facility
- Provider licensing
- Use of funds only for allowable services by appropriately licensed and authorized professionals
- Maintain client charts that include the required elements as detailed by the grantee, including:
  - An individualized plan of care
  - Types of rehabilitation services provided (physical and occupational therapy, speech pathology, low-vision training)
  - Dates, duration and location of services

**15. Standard:** Support for **Respite Care** that includes non-medical assistance for an HIV-infected client, provided in community or home-based settings and designed to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV/AIDS

*Note:* Funds may be used to support informal respite care provided issues of liability are addressed, payment made is reimbursement for actual costs and no cash payments are made to clients or primary caregivers

**Performance Measure/Method:**

- Documentation that funds are used only:
  - To provide non-medical assistance for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of that adult or minor in a community or home-based setting
- If grantee permits use of informal respite care arrangements, documentation that:
  - Liability issues have been addressed
  - A mechanism for payments has been developed that does not involve direct cash payment to clients or primary caregivers
  - Payments provide reimbursement for actual costs without over payment, especially if using vouchers or gift cards

**Contract Manager Responsibility:**

- Develop contracts that:
  - Clearly define respite care including allowable recipients, services and settings
  - Specify requirements for documentation of dates, frequency and settings of services
- If informal respite care arrangements are permitted, monitor providers to ensure that:
  - Issues of liability have been addressed in a way that protects the client, provider and Part B and PCN programs
  - A mechanism is in place to ensure that no cash payments are made to clients or primary caregivers
  - Payment made is for reimbursement of actual costs, especially if using vouchers or gift cards

**Provider Responsibility:**

- Maintain, and make available to the grantee on request, program records including:
  - Number of clients served
  - Settings/methods of providing care
- Maintain in each client file documentation of:

- Client and primary caretaker eligibility
- Services provided including dates and duration
- Setting/method of services
- Provide program and financial records and assurances that if informal respite care arrangements are used:
  - Liability issues have been addressed, with appropriate releases obtained that protect the client, provider and Part B and PCN programs
  - No cash payments are being made to clients or primary caregivers
  - Payment is reimbursement for actual costs

**16. Standard:** Funding for **Substance Abuse Treatment – Residential** to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a short-term residential health service setting

**Requirements:**

- Services to be provided by or under the supervision of a physician or other qualified personnel with appropriate and valid licensure and certification by the state in which the services are provided
- Services to be provided in accordance with a treatment plan
- Detoxification to be provided in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of a hospital)
- Limited acupuncture services permitted with a written referral from the client's primary health care provider, provided by certified or licensed practitioners wherever state certification or licensure exists

**Performance Measure/Method:**

- Documentation that:
  - Services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the state in which services are provided
  - Services provided meet the service category definition
  - Services are provided in accordance with a written treatment plan
- Assurance that services are provided only in a short-term residential setting
- Documentation that if provided, acupuncture services:
  - Are limited through some form of defined financial cap
  - Are provided only with a written referral from the client's primary care provider
  - Are offered by a provider with appropriate state license and certification if it exists

**Contract Manager Responsibility:**

- Develop contracts that clearly specify:
  - Allowable activities under this service category
  - The requirement that services be provided in a short-term residential health service setting
  - Limitations and permitted use of acupuncture
  - Requirements for a treatment plan including specified elements
  - The information that must be documented in each client's file
  - The information that is to be reported to the grantee

- Review staff licensure and certification and staffing structure to ensure that services are provided under the supervision of a physician or other qualified/licensed personnel
- Require assurance that services are provided in a short-term residential setting
- Monitor provider and review program records and client files for evidence of a treatment plan with the required components
- For any client receiving acupuncture services under this service category, documentation in the client file including:
  - Caps on use of Part B and PCN funds
  - A written referral from their primary health care provider
  - Proof that the acupuncturist has appropriate certification or licensure, if the state provides such certification or licensure

**Provider Responsibility:**

- Maintain, and provide to grantee on request, documentation of:
  - Provider licensure or certifications as required by the state in which service is provided; this includes licensures and certifications for a provider of acupuncture services
  - Staffing structure showing supervision by a physician or other qualified personnel
- Provide assurance that all services are provided in a short-term residential setting
- Maintain program records that document:
  - That all services provided are allowable under this service category
  - The quantity, frequency and modality of treatment services
- Maintain client files that document:
  - The date treatment begins and ends
  - Individual treatment plan
  - Evidence of regular monitoring and assessment of client progress
- In cases where acupuncture therapy services are provided, document in the client file:
  - A written referral from the primary health care provider
  - The quantity of acupuncture services provided

**17. Standard:** Support for **Treatment Adherence Counseling**, which is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments, provided by non-medical personnel outside of the Medical Case Management and clinical setting

**Performance Measure/Method:**

- Documentation that services provided under this category are:
  - Designed to ensure readiness for, and adherence to, complex HIV/AIDS treatments
  - Provided by non-medical personnel
  - Provided outside of the Medical Case Management and clinical setting

**Contract Manager Responsibility:**

- Develop contracts that clearly specify:
  - Allowable activities under this service category
  - The requirement that services be provided by non-medical personnel
  - The requirement that services be provided outside of the Medical Case Management and clinical setting
  - The information that must be documented in each client's file and reported to the grantee

- Monitor provider and review client records to ensure compliance with contractual and program requirements

**Provider Responsibility:**

- Provide assurances and maintain documentation that:
  - Services provided are limited to those permitted by the contract
  - Services are provided by non-medical personnel
  - Services are provided outside the Medical Care Management and clinical setting
- Maintain client charts that include the required elements as detailed by the grantee

**IV. Quality Management****1. Standard:** Implementation of a **Clinical Quality Management (CQM)** Program to:

- Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infections
- Develop strategies for ensuring that services are consistent with the guidelines for improvement in the access to and quality of HIV health services

## CQM program to include:

- A Quality Management Plan
- Quality expectations for providers and services
- A method to report and track expected outcomes
- Monitoring of provider compliance with HHS treatment guidelines and the Part B and PCN programs' approved Standards of Care
- *The state will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the state under the Part B and PCN programs*

**Performance Measure/Method:**

- Documentation that the Part B and PCN programs have in place a Clinical Quality Management Program that includes, at a minimum:
  - A Quality Management Plan
  - Quality expectations for providers and services
  - A method to report and track expected outcomes
  - Monitoring of provider compliance with HHS treatment guidelines and the Part B Program's approved standards of care for each funded service category
- Review of CQM program to ensure that providers are carrying out necessary CQM activities and reporting CQM performance data

**Contract Manager Responsibility:**

- Monitor progress towards a Quality Management Plan
- Specify in provider contracts the quality-related expectations for each service category
- Conduct chart reviews and visits to providers to monitor compliance with the Quality Management Plan and with Part B and PCN quality expectations

**Provider Responsibility:** Participate in quality management activities as contractually required; at a minimum:

- Compliance with relevant service category standards of care
- Collection and reporting of data for use in measuring performance
- Develop and implement a Quality Management Plan

## V. Other Service Requirements

1. **Standard: WICY – Women, Infants, Children, and Youth:** Amounts set aside for women, infants, children and youth to be determined based on each of these population's relative percentage of the total number of persons living with AIDS in the state

**Performance Measure/Method:**

- Documentation that the amount of Part B funding (only) spent on services for women, infants, children and youth is at least equal to the proportion each of these populations represents of the entire population of persons living with AIDS in the state

**Contract Manager Responsibility:** None

**Provider Responsibility:** Track and report to the grantee the amount and percentage of Part B funds expended for services to each priority population

2. **Standard:** Referral relationships with key points of entry: Requirement that Part B and PCN service providers maintain appropriate referral relationships with entities that constitute key points of entry

- Key points of entry defined in legislation are:
  - Emergency rooms
  - Substance abuse and mental health treatment programs
  - Detoxification centers
  - Detention facilities
  - Clinics regarding sexually transmitted disease
  - Homeless shelters
  - HIV disease counseling and testing sites
  - Health care points of entry specified by eligible areas
  - Federally Qualified Health Centers
  - Entities such as Ryan White Part C and D grantees

**Performance Measure/Method:** Documentation that written referral relationships exist between Part B and PCN service providers and key points of entry

**Contract Manager Responsibility:**

- Require in contracts that providers establish written referral relationships with defined key points of entry into care
- Review subcontractors' written referral agreements with specified points of entry
- Review documented client files to determine whether referral relationships are being used

**Provider Responsibility:**

- Establish written referral relationships with specified points of entry
- Document referrals from these points of entry

**VI. Prohibition on Certain Activities**

- 1 Standard: Employment and Employment-Readiness Services:** Prohibition on the use of Part B and PCN program funds to support employment, vocational or employment-readiness services

**Performance Measure/Method:**

- Signed contracts, grantee and provider assurances, and/or certifications that define and specifically forbid the use of Part B funds for unallowable activities
- Grantee review of provider budget and expenditures to ensure that they do not include any unallowable costs or activities

**Contract Manager Responsibility:**

- Include definitions of unallowable activities in agreements, purchase orders and requirements or assurances
- Include in financial monitoring a review of provider expenses to identify any unallowable costs
- Require provider budgets and expense reports with sufficient budget justification and expense detail to document that they do not include unallowable activities

**Provider Responsibility:**

- Maintain a file with signed provider agreement, assurances, and/or certifications that specify unallowable activities
- Ensure that budgets and expenditures do not include unallowable activities
- Ensure that expenditures do not include unallowable activities
- Provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs or activities

- 2 Standard: Maintenance of Privately Owned Vehicle:** No use of Part B and PCN funds for direct maintenance expenses (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance or license and registration fees

**Note:** This restriction does not apply to vehicles operated by organizations for program purposes

**Performance Measure/Method:**

- Implementation of actions specified in VI.1
- Documentation that Part B and PCN funds are not being used for direct maintenance expenses or any other costs associated with privately owned vehicles, such as lease or loan payments, insurance or license and registration fees – except for vehicles operated by organizations for program purposes

**Contract Manager Responsibility:**

- Carry out actions specified in VI.1

- Clearly define the prohibition against expenditures for maintenance of privately owned vehicles in contracts, including clarification of the difference between privately owned vehicles and vehicles owned and operated by organizations for program purposes

**Provider Responsibility:**

- Carry out actions specified in VI.1

**3 Standard: Additional Prohibitions:** No use of Part B and PCN Funds for the following activities or to purchase these items:

- Clothing
- Funeral, burial, cremation or related expenses
- Local or state personal property taxes (for residential property, private automobiles or any other personal property against which taxes may be levied)
- Household appliances
- Pet foods or other non-essential products
- Off-premise social/recreational activities or payments for a client's gym membership
- Purchase or improve land or to purchase, construct or permanently improve (other than minor remodeling) any building or other facility
- Pre-exposure prophylaxis

**Performance Measure/Method:**

- Implementation of actions specified in VI.1
- Review and monitoring of provider activities and expenditures to ensure that Part B and PCN funds are not being used for any of the prohibited activities

**Contract Manager Responsibility:**

- Carry out actions specified in VI.1
- Develop and implement a system to review and monitor provider program activities and expenditures and ensure a similar system to review and monitor grantee expenditures

**Provider Responsibility:**

- Carry out actions specified in VI.1

**VII. Data Reporting Requirements****1. Standard:** Submission of the online service providers report

**Performance Measure/Method:** Documentation that all service providers have submitted their sections of the online service providers report

**Contract Manager Responsibility:** N/A

**Provider Responsibility:**

- Report all the Part B (only) services the provider offers to clients during the funding year
- Submit both interim and final reports by the specified deadlines

**2. Standard:** Submission of the online client report

**Performance Measure/Method:** Documentation that all service providers have submitted their sections of the online client report

**Contract Manager Responsibility:** N/A

**Provider Responsibility:**

- Maintain client-level data on each client served, including in each client record demographic status, HIV clinical information, HIV-care medical and support services received and the client's Unique Client Identifier
- Submit this report online as an electronic file upload using the standard format
- Submit both interim and final reports by the specified deadlines

**VIII. Consortia (Part B only)**

- 1 Standard:** Consortium activities to include planning and periodic program evaluation as permitted under Ryan White legislation

**Performance Measure/Method:** N/A

**Contract Manager Responsibility:**

- Develop contracts with consortium guidelines that:
  - Clearly define allowable consortium activities

**Provider Responsibility:**

- Maintain, and share with the grantee upon request, program and financial records that document planning and program evaluation activities

- 2 Standard:** Consortia to submit to the state signed assurances in order to receive funding from the state under Part B Program

Assurances to affirm the following:

- Within the geographic area in which the consortium operates, populations and subpopulations of individuals and families with HIV/AIDS have been identified, particularly those experiencing disparities in access and services and/or residing in historically underserved communities
- The regional/geographic service plan established by the consortium is consistent with the state's comprehensive plan and addresses the special care and service needs of these populations and subpopulations of individuals and families with HIV/AIDS

**Performance Measure/Method:** Signed assurances from each consortium that affirm:

- Identification of populations and subpopulations of individuals and families with HIV/AIDS identified, particularly those experiencing disparities in access and services and residing in historically underserved communities
- Consortium regional/geographic service plan that is consistent with the comprehensive plan and addresses the special care and service needs of the specified populations and subpopulations

**Contract Manager Responsibility:**

- Provide guidance to consortia through contracts and written agreements on the need to submit the required assurances to the state in order to receive Part B funding
- Obtain from consortia the appropriate signed assurances as part of the annual funding cycle

**Provider Responsibility:** Sign assurances and submit to the state as required in order to receive Part B funds

**3 Standard:** Consortia to be required to submit applications to the state demonstrating that the consortium includes agencies and community-based organizations:

- With a record of service to populations and subpopulations with HIV/AIDS requiring care within the community to be served, and
- Representative of populations and subpopulations reflecting the local epidemic and located in areas in which such populations reside

**Performance Measure/Method:** Review of each consortium's application to ensure that it demonstrates the inclusion of agencies and community-based organizations:

- With a documented record of services to populations and subpopulations with HIV/AIDS requiring care within the community to be served
- With staff, clients and (for nonprofit providers) board members representative of populations and subpopulations reflecting the local incidence of HIV and that are located in areas which such populations reside

**Contract Manager Responsibility:** Implement an application process for consortia that meets specified requirements regarding the record of service and representativeness of consortium agencies and community-based organizations. Maintain on file a copy of each consortium's application

**Provider Responsibility:** Submit to the state an application that provides specific documentation that demonstrates the service record and representativeness of consortium agencies and community-based organizations

**4 Standard:** Each consortium to conduct **needs assessment** of service needs within the geographic area to be served and ensure participation by individuals living with HIV/AIDS in the needs assessment process

**Performance Measure/Method:** Documentation that each consortium has:

- Conducted a needs assessment to determine the service needs of the populations and subpopulations of individuals with HIV/AIDS and their families within the geographic area to be served
- Ensured the participation of individuals with HIV/AIDS in the needs assessment process

**Contract Manager Responsibility:**

- Develop contracts with consortia that specify the requirements for consortium needs assessments, including participation of individuals with HIV/AIDS
- Review needs assessment documents to ensure that requirements are met

**Provider Responsibility:**

- Conduct a needs assessment of the service needs of the populations and subpopulations of individuals with HIV/AIDS and their families within the geographic area to be served, meeting the requirements as specified by the state, including participation of individuals living with HIV/AIDS areas in the needs assessment process
- Provide a copy of the needs assessment to the state for review

**5 Standard:** Each consortium to have a **service plan** for the geographic region served that is based upon evaluations of service need and designed to meet local needs

Consortium to demonstrate adequate planning to:

- Meet the special needs of families with HIV/AIDS, including family-centered and youth-centered care and to provide assurances regarding content of the service plan
- Address disparities in access and services and historically underserved communities

State to receive assurances from consortia that through the service plan:

- Service needs will be addressed through the coordination and expansion of existing programs before new programs are created
- In metropolitan areas, the consortium's geographic service area corresponds to the geographic boundaries of local health and support service delivery systems to the extent practicable
- In rural areas, case management services will link available community support services to specialized HIV medical services
- Individuals living with HIV/AIDS have participated in the needs assessment and service planning

**Performance Measure/Method:**

- A service plan description for each consortium providing documentation and assurances that the service plan addresses service needs and:
  - Specifies that service needs will be addressed through the coordination and expansion of existing programs before new programs are created
  - Provides for geographic service areas in metropolitan areas that correspond, to the extent practicable, to boundaries of local health and support service delivery systems
  - Ensures that rural case management services link available community support services to specialized HIV medical services
  - Ensures the participation of individuals living with HIV/AIDS in needs assessment and service planning
- Documentation of adequate planning to:
  - Meet the special needs of families with HIV/AIDS, including family- and youth-centered HIV care services
  - Address disparities in access and services of historically underserved communities

**Contract Manager Responsibility:**

- Develop contracts with consortia that outline the requirements for service plans and planning for families with HIV/AIDS
- Require specified assurances related to
  - Coordination and expansion of existing programs
  - Use of common service boundaries in urban areas

- Use of case management to link support services to specialized HIV medical care in rural areas
- Participation of individuals living with HIV/AIDS in needs assessment and service planning

**Provider Responsibility:**

- Develop regional/geographic service plans for the consortia region that include required components and focus areas, attention to planning for families with HIV/AIDS and participation of individuals living with HIV/AIDS
- Provide specified written assurances to the state

- 6 Standard:** Consultation by each consortium with representatives of required entities in the establishment of the service plan for the consortium region

At a minimum, consultation to include representatives of at least the following:

- Public health or other entity that provides or supports HIV-related ambulatory and outpatient health care services within the geographic area to be served
- At least one community-based organization organized solely to provide HIV/AIDS services
- Funded Part D program representatives; if none located in the consortium region, then organizations with a history of serving women, infants, children youth and families living with HIV
- Diverse entities of the categories included in the membership of a Part A HIV health services planning council, where applicable

**Performance Measure/Method:** Documentation in each consortium's service plan that the establishment of the service plan involved consultation with representatives of at least the following:

- Public health or other entity that provides or supports HIV-related ambulatory and outpatient health care services
- At least one community-based organization whose sole purpose is to provide HIV/AIDS services
- Funded Part D program representatives or, if none, organizations with a history of serving women, infants, children youth and families living with HIV
- Diverse entities like those included as members of Part A HIV health services planning councils, where applicable

**Contract Manager Responsibility:**

- Provide guidance to consortia through contracts and written agreements that representatives of specified entities and types of entities must be consulted in the establishment of the service plan for the consortium region
- Review documentation of consultation with required entities, such as meeting dates, minutes, agendas and attendance lists

**Provider Responsibility:** Maintain, and provide to the grantee on request, documentation that shows the involvement of the required representatives in the development of the service plan for the consortium region, such meeting dates, minutes, agendas and attendance lists

- 7. Standard:** Each consortium to conduct periodic evaluation of its success in responding to identified needs and the cost-effectiveness of mechanisms used to deliver comprehensive care

Each consortium required to

- Report to the state the results of its evaluation
- Make available upon request the data and methodology information needed for the state to conduct an independent evaluation

**Performance Measure/Method:**

- Documentation of guidance provided to consortia by the state regarding evaluation requirements
- Documentation that each consortium is conducting periodic evaluation of both consortium success in responding to identified needs and cost-effectiveness of mechanisms used to deliver comprehensive care, such as timetables and methodology for evaluations of success in meeting needs and cost-effectiveness of service delivery mechanisms
- Grantee review of completed evaluations of service success and cost-effectiveness of service interventions in accordance with the established timeframes
- Documentation that consortia are providing the state copies of evaluation results and both data and methodology necessary for the state to conduct independent evaluation

**Contract Manager Responsibility:**

- Provide clear guidance to consortia in contract language and agreements regarding evaluation requirements, including:
  - Legislative requirements for evaluation
  - State timetables and other guidelines for evaluation, such as a multi-year evaluation plan and description of what evaluation activities will be conducted each year
- Requirement to report results and make data and methodology information available to the state for use in conducting independent evaluation
- Receive and review evaluation results and methods

**Provider Responsibility:**

- Develop plans and methods to evaluate service success and the cost-effectiveness of mechanisms used to deliver comprehensive care
- Conduct evaluations in accordance with guidelines and timetables determined by the state
- Make evaluation results and methodology information available to the state on request for review and for use in conducting independent evaluation

## **G. Selected References**

[Ryan White Comprehensive AIDS Resources Emergency Act of 1990](#)

[Ryan White HIV/AIDS Treatment Extension Act of 2009](#)

[42 U.S.C. 1320 7b\(b\)](#) Social Security

2 CFR 215 - Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-Profit Organizations (OMB Circular A-110)

[http://www.access.gpo.gov/nara/cfr/waisidx\\_10/2cfr215\\_10.html](http://www.access.gpo.gov/nara/cfr/waisidx_10/2cfr215_10.html)

2 CFR 220 - Cost Principles for Education Institutions (OMB Circular A-21)

[http://www.access.gpo.gov/nara/cfr/waisidx\\_10/2cfr220\\_10.html](http://www.access.gpo.gov/nara/cfr/waisidx_10/2cfr220_10.html)

2 CFR 225 - Cost Principles for State, Local and Indian Tribal Governments (OMB Circular A-87)

[http://www.access.gpo.gov/nara/cfr/waisidx\\_10/2cfr225\\_10.html](http://www.access.gpo.gov/nara/cfr/waisidx_10/2cfr225_10.html)

- 2 CFR 230 - Cost Principles for Non-Profit Organizations (OMB Circular A-122)  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_10/2cfr230\\_10.html](http://www.access.gpo.gov/nara/cfr/waisidx_10/2cfr230_10.html)
- 29 CFR 516 - Fair Labor Standards Act  
<http://www.access.gpo.gov/cgi-bin/cfrassemble.cgi?title=201029>
- 45 CFR 74 - Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations and Commercial Organizations  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/45cfr74\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/45cfr74_09.html)
- 45 CFR 77 - Remedial Actions Applicable to Letter of Credit Administration  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/45cfr77\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/45cfr77_09.html)
- 45 CFR 78 - Conditions for Waiver of Denial of Federal Benefits  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/45cfr78\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/45cfr78_09.html)
- 45 CFR 79 - Program Fraud Civil Remedies  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/45cfr79\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/45cfr79_09.html)
- 45 CFR 80 - Nondiscrimination Under Programs Receiving Federal Assistance through the Department of Health And Human Services Effectuation of Title VI of the Civil Rights Act of 1964  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/45cfr80\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/45cfr80_09.html)
- 45 CFR 82 - Government-wide Requirements for Drug-Free Workplace (Financial Assistance)  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/45cfr82\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/45cfr82_09.html)
- 45 CFR 92 - Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local and Tribal Governments  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/45cfr92\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/45cfr92_09.html)
- 45 CFR 93 - New Restrictions on Lobbying  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/45cfr93\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/45cfr93_09.html)
- 45 CFR 94 - Responsible Prospective Contractors  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/45cfr94\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/45cfr94_09.html)
- 42 CFR 50 - Policies of General Applicability  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/42cfr50\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/42cfr50_09.html)
- 48 CFR 31 - Contract Cost Principles and Procedures  
[http://www.access.gpo.gov/nara/cfr/waisidx\\_09/48cfr31\\_09.html](http://www.access.gpo.gov/nara/cfr/waisidx_09/48cfr31_09.html)

OMB A-21 - Cost Principles for Educational Institutions

[http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a021/a21\\_2004.pdf](http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a021/a21_2004.pdf)

OMB A-87 - Cost Principles for State, Local and Indian Tribal Governments

[http://www.whitehouse.gov/sites/default/files/omb/assets/agencyinformation\\_circulars\\_pdf/a87\\_2004.pdf](http://www.whitehouse.gov/sites/default/files/omb/assets/agencyinformation_circulars_pdf/a87_2004.pdf)

OMB A-102 - Grants and Cooperative Agreements with State and Local Governments

<http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a102/a102.pdf>

OMB A-110 - Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals and Other Non-Profit Organizations

[http://www.whitehouse.gov/omb/circulars\\_a110/](http://www.whitehouse.gov/omb/circulars_a110/)

OMB A-122 - Cost Principles for Non-Profit Organizations

[http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a122/a122\\_2004.pdf](http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a122/a122_2004.pdf)

OMB A-133 - Audits of States, Local Governments and Non-Profit Organizations

[http://www.whitehouse.gov/sites/default/files/omb/assets/a133/a133\\_revised\\_2007.pdf](http://www.whitehouse.gov/sites/default/files/omb/assets/a133/a133_revised_2007.pdf)

[HRSA Policies and Program Letters](#)

[Ryan White Part B Manual 2013](#)

## SECTION 5: REPORTING REQUIREMENTS

### A. Reporting Overview

All HIV/AIDS Patient Care Resources contracted providers and county health departments are required to adhere to reporting requirements as defined by the state and federal governments and any subsequent changes to these requirements enacted during the program year. Providers must establish data collection systems adequate to accurately meet state and federal reporting requirements in a timely manner.

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.

In order to assist contractors and county health departments in meeting their reporting requirements, the Florida Department of Health, HIV/AIDS and Hepatitis Section, has developed AIMS 2.0 - the AIDS Information Management System. AIMS 2.0 is a web-based, aggregate level reporting system which allows primary contractors and county health departments to electronically report to the HIV/AIDS and Hepatitis Section. Questions or concerns about AIMS 2.0 reporting should be directed to a member of the Reporting and Information Systems staff. AIMS 2.0 access and training can be arranged by contacting a member of the Reporting and Information Systems staff.

The Reporting Requirements for Programs Funded by the Ryan White HIV/AIDS Treatment Modernization Act, Part B is designed to answer all your reporting questions. Appendix G, “Units of Service – Definitions,” lists what constitutes a unit of service for each care service category.

### B. Report Submission (KEY explaining the shading of deadline charts included on page 4)

<b>Ryan White Part B Consortia and Emerging Communities</b>		
<b>Report Name</b>	<b>Due Date*</b>	<b>Responsibility</b>
<i>Monthly Expenditure and Reimbursement Report</i>	20 <sup>th</sup> of each month following the month being reported	Contract Manager and Provider
<i>Monthly Demographic Report</i>	20 <sup>th</sup> of each month following the month being reported	Provider
<i>Minority Business Enterprise Report</i>	20 <sup>th</sup> of each month	Contract Manager and Provider
<i>Income/Expenditure Report</i>	20 <sup>th</sup> of each month	Contract Manager and Provider
<i>Implementation Plan</i> (April 1-March 31 contract year)	TBA ( <i>Word Document</i> )	Contract Manager and Provider
<i>Revised Implementation Plan</i> (April 1 -March 31 contract year)	TBA ( <i>Word Document</i> )	Contract Manager and Provider

<b>Ryan White Part B Consortia and Emerging Communities</b>		
<b>Report Name</b>	<b>Due Date*</b>	<b>Responsibility</b>
<b><i>Provider/Sub-contractor Report</i></b> (April 1-March 31 of contract year)	May 30 of contract year	Provider
<b><i>WICY Report</i></b> (April 1-March 31 contract year)	July 15 of contract year <b><i>(Word Document)</i></b>	Provider
<b><i>Annual Progress Report</i></b> (April-Final contract year)	July 15 of contract year	Provider
<b><i>Mid-Year Progress Report</i></b> (April -September contract year)	October 14 of contract year	Provider
<b><i>Program Data Report</i></b> (January-December contract year)	February of contract year	Provider
<b><i>Client Complaint, Grievance, and Appeal Procedures Log</i></b> (April 1-March 31 contract year)	20 <sup>th</sup> of each month following the month being reported	Lead Agency and/or Provider

<b>Private Insurance Continuation Program (PICP)</b>		
<b>Report Name</b>	<b>Due Date*</b>	<b>Responsible Party</b>
<b><i>Monthly Expenditure and Reimbursement Report</i></b>	20 <sup>th</sup> of each month following the month being reported	Contract Manager and Provider
<b><i>Quarterly Demographic Report</i></b>	20 <sup>th</sup> of each quarter	Provider
<b><i>Implementation Plan</i></b> (April 1-March 31 contract year)	TBA	Contract Manager and Provider
<b><i>Revised Implementation Plan</i></b> (April 1-March 31 contract year)	May 30 of contract year <b><i>(Word Document)</i></b>	Provider
<b><i>Annual Progress Report</i></b> (April 1-March 31 contract year)	July 15 of contract year <b><i>(Word Document)</i></b>	Provider
<b><i>WICY Report</i></b> (April 1-March 31 contract year)	July 15 of contract year <b><i>(Word Document)</i></b>	Provider
<b><i>Mid-Year Progress Report</i></b> (April-September contract year)	October 14 after contract year <b><i>(Word Document)</i></b>	Provider
<b><i>Program Data Report</i></b> (January-December calendar year)	February after contract year	Provider

<b>County Health Department General Revenue Funding (Schedule C – 4B funds)</b>		
<b>Report Name</b>	<b>Due Date*</b>	<b>Responsible Party</b>
<i>Monthly Expenditure and Reimbursement Report</i>	20 <sup>th</sup> of each month following the month being reported	CHD AIMS 2.0 user and Provider
<i>Monthly Demographic Report</i>	20 <sup>th</sup> of each month following the month being reported	Provider
<i>Annual Spending Plan</i> (July 1 – June 30 contract year)	July of contract year or as stated by Reporting Section <i>(Excel Document)</i>	CHD AIMS 2.0 User, Provider, Contract Manager, or HAPC
<b>County Health Department General Revenue Funding (Schedule C – 4B funds)</b>		
<b>Report Name</b>	<b>Due Date*</b>	<b>Responsible Party</b>
<i>Client Complaint, Grievance, and Appeal Procedures Log</i> (April 1-March 31 contract year)	20 <sup>th</sup> of each month following the month being reported	Lead Agency and/or Provider

<b>Patient Care Networks General Revenue Funding</b>		
<b>Report Name</b>	<b>Due Date*</b>	<b>Responsible Party</b>
<i>Monthly Expenditure and Reimbursement Report</i>	20 <sup>th</sup> of each month following the month being reported	Contract Manager and Provider
<i>Monthly Demographic Report</i>	20 <sup>th</sup> of each month following the month being reported	Provider
<i>Minority Business Enterprise Report</i>	Consult with the Department of Health Minority Coordinator at (850) 245-4199	Contract Manager
<i>Annual Contract Negotiation</i>	TBA by Community Programs Staff	Contract Manager
<i>Provider/Sub-contractor Report</i>	November 1	Provider
<i>Client Complaint, Grievance, and Appeal Procedures Log</i> (July 1 – June 30 contract year)	20 <sup>th</sup> of each month following the month being reported	Lead Agency and/or Provider

<b>Housing Opportunities for Persons with AIDS (HOPWA) (Housing and Urban Development – HUD)</b>		
<b>Report Name</b>	<b>Due Date*</b>	<b>Responsible Party</b>
<i>Monthly Expenditure and Reimbursement Report</i>	20 <sup>th</sup> of each month following the month being reported	Contract Manager and Project Sponsor
<i>Monthly Demographic Report</i>	20 <sup>th</sup> of each month following the month being reported	Project Sponsor
<i>Minority Business Enterprise Report</i>	Consult with the Department of Health Minority Coordinator at (850) 245-4199	Contract Manager
<i>Client Complaint, Grievance, and Appeal Procedures Log</i>	20 <sup>th</sup> of each month following the month being reported	Lead Agency and/or Provider

**KEY - Programs with shaded backgrounds are to submit reports through AIMS 2.0.**

Additional AIMS 2.0 reporting requirements may be added as development of the information system continues. Questions or concerns about AIMS 2.0 reporting as well as requests for training and technical assistance should be directed to a member of the Reporting and Information Systems staff.

**\*In the event that a reporting due date falls on a weekend or holiday, the report will be due on the following business day.**

## **Appendix A: Florida Department of Health, HIV/AIDS and Hepatitis Section Administered Programs**

### **Ryan White Part B**

The Ryan White HIV/AIDS Treatment Extension Act of 2009 hereinafter referred to as Ryan White Program, provides the Federal HIV/AIDS programs in the Public Health Service Act under Title XXVI flexibility to respond effectively to the changing epidemic. The new law changes how Ryan White funds can be used with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS across this country.

The Ryan White Program is not an entitlement program such as Medicaid or Medicare. Service availability is directly related to funding allocations. The Ryan White Program provides federal funding for outpatient medical care, pharmaceuticals, dental services, mental health counseling, case management and many other services to eligible individuals. The Department contracts with fiscal lead agencies to provide these services in the designated consortium areas throughout the state. Florida's Ryan White Part B HIV consortia are established as the planning bodies for the Ryan White Part B Program and submit comprehensive plans to the department every three years.

### **Emerging Communities**

HRSA defines an Emerging Community as an area with a cumulative total of at least 500 but fewer than 1,000 AIDS cases during the most recent five years. Ryan White Part B Emerging Communities are funded annually, provide services very similar to consortia and coordinate services and planning activities with their local consortium.

### **Patient Care Networks**

There are seven HIV/AIDS Patient Care Network programs (PCN) in the state of Florida. These programs are funded by General Revenue through the Florida legislature to provide HIV/AIDS patient care programs with similar services as the Ryan White Part B programs. As with the Ryan White Part B Program, the department contracts with fiscal lead agencies to provide these services in the PCN areas.

### **General Revenue**

There are 32 county health departments that receive specific General Revenue funding to operate HIV/AIDS patient care programs to improve the health of HIV/AIDS patients.

### **HOPWA**

The Housing Opportunities for Persons with AIDS (HOPWA) program is a federal Department of Housing and Urban Development funded program that provides temporary mortgage, rent and utility assistance to eligible individuals with HIV/AIDS. There are ten HOPWA programs statewide administered by the Department of Health.

**ADAP**

The AIDS Drug Assistance Program (ADAP) provides HIV drug treatments for people who do not have private health insurance, do not qualify for Medicaid or Medicare and cannot afford their medications. It also covers the cost of routine labs, such as viral load and CD4 counts, for enrolled clients.

**Insurance Continuation Program**

The Private Insurance Continuation Program (formerly known as the AIDS Insurance Continuation Program) is a Florida Department of Health program for Floridians who have HIV/AIDS and need assistance paying their health insurance costs.

## Appendix B: Glossary of Terms and Acronyms

**ADA** – Americans with Disabilities Act

**ADAP** – AIDS Drug Assistance Program

**AIDS** – Acquired Immunodeficiency Syndrome

**AIMS 2.0** – AIDS Information Management System 2.0 is a web-based, aggregate level reporting system developed by the Florida Department of Health, HIV/AIDS and Hepatitis Section, which allows primary contractors and county health departments to electronically report to the HIV/AIDS and Hepatitis Section.

**CAG** – Consumer Advisory Group

**CARE** – Comprehensive AIDS Resources Emergency

**CAREWare** – The electronic health information system developed by HRSA to track information on clients receiving care under the Ryan White HIV/AIDS Program.

**CD4 (T-cells)** – Blood cells which are crucial to helping the body fight infections and the main target of HIV. A CD 4 count below 200 is an AIDS-defining condition.

**CFR** – Code of Federal Regulations

**CHD** – County Health Department

**CQM** – Clinical Quality Management

**Department** – Florida Department of Health

**DFS** – Department of Financial Services (state)

**DOHP** – Department of Health Policy (state)

**EC** – Emerging Communities

**FCPN** – Florida Comprehensive Planning Network

**FICA** – Federal Insurance Contributions Act - FICA taxes are deducted from the pay of most American workers to support Social Security programs.

**FPL** – Federal Poverty Level

**FS** – Florida Statute

**FTE** – Full-Time Equivalent

**FY** – Fiscal Year

**GMO** – Grants Management Office, Department of HHS (federal)

**HAART** – Highly Active Antiretroviral Therapy

**HAB** – HIV/AIDS Bureau, HRSA (federal)

**HAPC** – HIV/AIDS Program Coordinator

**HCFA** – Health Care Financing Administration, Department of HHS (federal)

**HERR** – Health Education Risk Reduction

**HIV** – Human Immunodeficiency Virus

**HOPWA** – Housing Opportunities for Persons with AIDS

**HRSA** – Health Resources and Services Administration. A public health service agency that administers programs designed to increase health care for the medically underserved. This includes the Ryan White Program and education and training programs for health care providers and community service workers who care for AIDS patients. HRSA also administers programs that demonstrate how communities can organize their health care resources to develop an integrated, comprehensive system of care for those with AIDS and HIV infection.

**OEI** – Office of Evaluations and Inspections, Office of the Inspector General, Department of HHS (federal)

**OMB** – Office of Management and Budget, White House (federal)

**Part A** – That part of the Ryan White HIV/AIDS Treatment Extension Act of 2009 that provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic.

**Part B** – That part of the Ryan White HIV/AIDS Treatment Extension Act of 2009 administered by the state through contracts with local lead fiscal agencies in Florida's 14 consortium areas.

**Part C** – The Early Intervention Services (EIS) program of the Ryan White HIV/AIDS Treatment Extension Act of 2009 that funds comprehensive primary health care in an outpatient setting for people living with HIV disease.

**Part D** – That part of the Ryan White HIV/AIDS Treatment Extension Act of 2009 that provides family-centered care involving outpatient or ambulatory care (directly or through contracts) for women, infants, children, and youth with HIV/AIDS. Grantees are expected to provide primary medical care, treatment and support services to improve access to health care.

**PCN** – General Revenue Patient Care Network

**PCPG** – Patient Care Planning Group

**PICP** – Private Insurance Continuation Program (formerly known as AIDS Insurance Continuation Program)

**RDR** – Ryan White Program Data Report

**Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (42 USC 300ff)** – This legislation was passed by Congress on August 18, 1990 and is authorized every five years. The newly reauthorized Ryan White HIV/AIDS Treatment Extension Act of 2009 focuses on life-saving and life-extending services and increased accountability for funding. It also provides more flexibility to the Secretary of Health and Human Services to direct funding of the areas of greatest need.

**SCSN** – Statewide Coordinated Statement of Need is a mechanism for addressing key HIV/AIDS care issues and enhancing coordination across Ryan White Programs. Section 2617(b) (6) of the revised 2006 Ryan White CARE Act requires: “an assurance that the public health agency administering the grant for the state will periodically convene a meeting of individuals with HIV/AIDS, members of a Federally recognized Indian tribe as represented in the State, representatives of grantees under each part of this title, providers, and public agency representatives for the purpose of developing and implementing a statewide coordinated statement of need.” The state Part B program is responsible for coordinating the SCSN.

**Sliding Fee Scale** – The HIV/AIDS and Hepatitis Section procedures for implementing the requirements regarding imposition of charges for services for eligible persons between 101% and 300% of the Federal Poverty Level in accordance with the Ryan White CARE Act of 1990, as amended in 2009.

**TBA** – To Be Announced

**USC** – United States Code (federal)

**VA** – Department of Veterans Affairs (federal)

**WICY** – Women, Infants, Children and Youth













- j) Insurance plans?
- k) Retirement plans?
- l) Establishing and maintaining personnel records?
- 4. Are there written policies and procedures designed to ensure the confidentiality of personnel records and define who has access to various types of personnel information?
- 5. Is each staff member appraised on performance at least annually?
- 6. Is the staff member asked to review and comment on the evaluation?
- 7. Is the staff member asked to sign the evaluation to verify that he has been informed of its content?
- 8. Does the provider give job descriptions to each employee in writing at the time of his appointment, as well as written personnel policies and procedures?
- 9. Is a complete personnel record kept on each person employed by the provider?
- 10. Is a staff member responsible for implementation and coordination of personnel policies and procedures?


**Comments:**

## Appendix D: HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1



<b>Performance Measure:</b> ARV Therapy for Pregnant Women	<b>OPR-Related Measure:</b> Yes <a href="http://www.hrsa.gov/performance/measure/review/measure.htm">www.hrsa.gov/performance/measure/review/measure.htm</a>
Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy	
<b>Numerator:</b>	Number of HIV-infected pregnant women who were prescribed antiretroviral therapy during the 2 <sup>nd</sup> and 3 <sup>rd</sup> trimester
<b>Denominator:</b>	Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges <sup>1</sup> , i.e. MD, PA, NP at least once in the measurement year
<b>Patient Exclusions:</b>	<ol style="list-style-type: none"> <li>1. Patients whose pregnancy is terminated</li> <li>2. Pregnant patients who are in the 1<sup>st</sup> trimester and newly enrolled in care during last three months of the measurement year</li> </ol>
<b>Data Element:</b>	<ol style="list-style-type: none"> <li>1. Is the client HIV-infected? (Y/N) <ol style="list-style-type: none"> <li>a. If yes, is the client female? (Y/N) <ol style="list-style-type: none"> <li>i. If yes, was she pregnant during the reporting period? (Y/N) <ol style="list-style-type: none"> <li>1. If yes, was she on antiretroviral therapy during this reporting period? (Y/N)</li> </ol> </li> </ol> </li> </ol> </li> </ol>
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Ryan White Program Data Report, Section 5, Item 53 may provide data useful in establishing a baseline for this performance measure</li> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic data base</li> <li>• Medical record data abstraction by grantee of a sample of records</li> </ul>
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	None available at this time.
<b>Outcome Measures for Consideration:</b>	<ul style="list-style-type: none"> <li>◦ Rate of perinatal transmission in the measurement year</li> <li>◦ Number of events of perinatal transmission in the measurement year</li> </ul>
<b>Basis for Selection and Placement in Group 1:</b>	
<p>Treatment recommendations for pregnant women infected with HIV-1 have been based on the belief that therapies of known benefit to women should not be withheld during pregnancy unless there are known adverse effects on the mother, fetus, or infant and unless these adverse effects outweigh the benefit to the woman. Antiretroviral therapy can reduce perinatal HIV-1 transmission by nearly 70%.<sup>2</sup></p> <p>Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission. Data collection is currently feasible and measure has a strong evidence base supporting the use.</p>	

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<p><b>US Public Health Service Guidelines:</b></p> <p>Health-care providers considering the use of antiretroviral agents for HIV-1 infected women during pregnancy must take into account two separate but related issues:</p> <ul style="list-style-type: none"> <li>• Antiretroviral treatment of maternal HIV-1 infection, and</li> <li>• Antiretroviral chemoprophylaxis to reduce the risk for perinatal HIV-1 transmission</li> </ul> <p>The benefits of antiretroviral therapy for a pregnant woman must be weighed against the risk of adverse events to the woman, fetus, and newborn. Although ZDV chemoprophylaxis alone has substantially reduced the risk for perinatal transmission, antiretroviral monotherapy is now considered suboptimal for treatment of HIV-1 infection, and combination drug regimens are considered the standard of care for therapy. Initial evaluation of an infected pregnant woman should include an assessment of HIV-1 disease status and recommendations regarding antiretroviral treatment or alteration of her current antiretroviral regimen.</p> <p>This assessment should include the following:</p> <ul style="list-style-type: none"> <li>• Evaluation of the degree of existing immunodeficiency determined by CD4 T-cell count,</li> <li>• Risk for disease progression as determined by the level of plasma RNA,</li> <li>• History of prior or current antiretroviral therapy,</li> <li>• Gestational age, and</li> <li>• Supportive care needs.</li> </ul> <p>Decisions regarding initiation of therapy should be the same for women who are not currently receiving antiretroviral therapy and for women who are not pregnant, with the additional consideration of the potential impact of such therapy on the fetus and infant.</p> <p>Further, use of ZDV alone should not be denied to a woman who wishes to minimize exposure of the fetus to other antiretroviral drugs and therefore, after counseling, chooses to receive only ZDV during pregnancy to reduce the risk for perinatal transmission.<sup>1</sup></p>
<p><b>References/Notes:</b></p> <p><sup>1</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.</p> <p><sup>2</sup> Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States (<a href="http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf">http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf</a>)</p>

<b>Performance Measure:</b> CD4 T-Cell Count		<b>OPR-Related Measure:</b> Yes <a href="http://www.hrsa.gov/performance/performancereview/measures.htm">www.hrsa.gov/performance/performancereview/measures.htm</a>																					
Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year																							
<b>Numerator:</b>	Number of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year																						
<b>Denominator:</b>	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges <sup>1</sup> , i.e. MD, PA, NP at least once in the measurement year																						
<b>Patient Exclusions:</b>	1. Patients newly enrolled in care during last six months of the year																						
<b>Data Element:</b>	1. Is the client HIV-infected? (Y/N) a. If yes, did the client have a CD4 count test conducted during the reporting period? (Y/N) a. If yes, list the quarters of these tests																						
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic data base</li> <li>• HIVQUAL reports on this measure for grantee under review</li> <li>• Medical record data abstraction by grantee of a sample of records</li> </ul>																						
<b>National Goals, Targets, or Benchmarks for Comparison</b>	IHI Goal: 90% <sup>2</sup> National HIVQUAL Data: <sup>3</sup> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>87.2%</td> <td>87.7%</td> <td>90.3%</td> <td>87.5%</td> </tr> <tr> <td>Top 25%</td> <td>74.2%</td> <td>78.0%</td> <td>76.6%</td> <td>78.8%</td> </tr> <tr> <td>Median*</td> <td>61.0%</td> <td>62.7%</td> <td>63.9%</td> <td>62.5%</td> </tr> </tbody> </table> *from HAB data base				2003	2004	2005	2006	Top 10%	87.2%	87.7%	90.3%	87.5%	Top 25%	74.2%	78.0%	76.6%	78.8%	Median*	61.0%	62.7%	63.9%	62.5%
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<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"> <li>◦ Rate of opportunistic infections in the measurement year</li> <li>◦ Rate of clients with progression to AIDS in the measurement year</li> <li>◦ Mortality rates</li> </ul>																						
<b>Basis for Selection and Placement in Group 1:</b>																							
<p>The CD4 T-cell count plays a vital role in determining the staging of HIV disease and indicating the need for prophylaxis against opportunistic infections. It continues to be used in decisions regarding initiation or adjustment of antiretroviral treatment.</p> <p>The most recent CD4 T-cell count is the strongest predictor of subsequent disease progression and survival, according to clinical trials and cohort studies data on patients receiving antiretroviral therapy.<sup>4</sup></p> <p>Measure reflects important aspects of care that significantly impacts survival and mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.</p>																							
<b>US Public Health Service Guidelines:</b>																							
" In general, CD4 T-cell count should be determined every three to six months to (1) determine when to start antiretroviral in patients who do not meet the criteria for initiation; (2) assess immunologic response to antiretroviral therapy; and (3) assess the need for initiating chemoprophylaxis for opportunistic infections." <sup>3</sup>																							
<b>References/Notes:</b>																							
Guidelines state that CD4 T-cell counts should be measured at least every 3-4 months depending on the stage of the disease. The timeframe of 6 months was determined by clinical expert consensus for the																							

purpose of this measure, but can and should be measured at more frequent intervals if needed.

<sup>1</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.

<sup>2</sup> IHI Measure reads, “Percent of Patients/Clients with a CD4 Count Test in the Past 4 Months” (<http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/Percentof+patientswithaCD4counttestinthepast4months.htm>)

<sup>3</sup> National HIVQUAL data looks at the percent of clients who have a CD4 T-cell count done every four months, not every six months.

(<http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>)

<sup>4</sup> Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services. December 1, 2007; 1-143. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed December 12, 2007.

<b>Performance Measure:</b> HAART		<b>OPR-Related Measure:</b> Yes <a href="http://www.hrsa.gov/performance/performancereview/measures.htm">www.hrsa.gov/performance/performancereview/measures.htm</a>																					
Percentage of clients with AIDS who are prescribed HAART																							
<b>Numerator:</b>	Number of clients with AIDS who were prescribed a HAART regimen <sup>1</sup> within the measurement year																						
<b>Denominator:</b>	Number of clients who: <ul style="list-style-type: none"> <li>• have a diagnosis of AIDS (history of a CD4 T-cell count below 200 cells/mm<sup>3</sup> or other AIDS-defining condition<sup>2</sup>), and</li> <li>• had at least one medical visit with a provider with prescribing privileges<sup>3</sup>, i.e. MD, PA, NP in the measurement year.</li> </ul>																						
<b>Patient Exclusions:</b>	1. Patients newly enrolled in care during last three months of the measurement year																						
<b>Data Element:</b>	1. Is the client diagnosed with CDC-defined AIDS? (Y/N) a. If yes, was the client prescribed HAART during the reporting period? (Y/N)																						
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Ryan White Program Data Report, Section 2, Items 26 and 31 may provide data useful in establishing a baseline for this performance measure</li> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic data base.</li> <li>• HIVQUAL reports on this measure for grantee under review</li> <li>• Medical record data abstraction by grantee of a sample of records</li> </ul>																						
<b>National Goals, Targets, or Benchmarks for Comparison</b>	IHI Goal: 90% <sup>4</sup> CDC and HIVRN data consistent that 80% of those in care “eligible for ARVs” on tx. This includes CD4<350 and not just AIDS. <sup>5,6</sup> National HIVQUAL Data: <sup>7,8</sup> <table border="1" style="margin-left: 20px;"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Median*</td> <td>100%</td> <td>88.9%</td> <td>95.7%</td> <td>100%</td> </tr> </tbody> </table> *from HAB data base				2003	2004	2005	2006	Top 10%	100%	100%	100%	100%	Top 25%	100%	100%	100%	100%	Median*	100%	88.9%	95.7%	100%
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Median*	100%	88.9%	95.7%	100%																			
<b>Outcome Measures for Consideration:</b>	<ul style="list-style-type: none"> <li>◦ Rate of opportunistic infections in the measurement year</li> <li>◦ Rate of HIV-related hospitalizations in the measurement year</li> <li>◦ Mortality rates</li> </ul>																						
<b>Basis for Selection and Placement in Group 1:</b>																							
“Randomized clinical trials provide strong evidence of improved survival and reduced disease progression by treating symptomatic patients and patients with CD4 T-cells <200 cells/mm <sup>3,9</sup> .” Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission. Data collection is currently feasible and measure has a strong evidence base supporting the use.																							
<b>US Public Health Service Guidelines:</b>																							
“Antiretroviral therapy is recommended for all patients with history of an AIDS-defining illness or severe symptoms of HIV infection regardless of CD4 T-cell count.” <sup>10</sup>																							

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**References/Notes:**

<sup>1</sup> Many authorities recommend two baseline CD4 T-cell measurements before decisions are made to initiate antiretroviral therapy because of wide variations in results. The test should be repeated yet a third time if discordant results are seen. The optimal time to initiate antiretroviral therapy among asymptomatic patients with CD4 T-cell counts  $>200$  cells/mm<sup>3</sup> is unknown. This measure focuses strictly on the subset of patients for whom antiretroviral therapy is unequivocally recommended—those with a CD4 T-cell count below 200 cells/mm<sup>3</sup> or history of another AIDS-defining condition. Asymptomatic patients with CD4 T-cell counts of 201–350 cells/mm<sup>3</sup> should be offered treatment. For asymptomatic patients with CD4 T-cell of  $>350$  cells/mm<sup>3</sup> and plasma HIV RNA  $>100,000$  copies/ml most experienced clinicians defer therapy but some clinicians may consider initiating treatment. (See reference 8 below)

<sup>2</sup> AIDS Defining conditions are noted in CDC. 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. MMWR 1992;41(no. RR-17). (<http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm>)

<sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.

<sup>4</sup> IHI Measure reads, “Percent of Patients with Appropriate ARV Therapy Management”  
<http://www.ihf.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientswithAppropriateARVTherapyManagement.htm>

<sup>5</sup> Gebo, JAIDS January 2005, vol. 38, pp. 96-103.

<sup>6</sup> Teshale Abstract #167, CROI 2005.

<sup>7</sup> The National HIVQUAL data may not be directly comparable due to varying exclusions. Indicator definitions can be accessed at <http://www.hivguidelines.org/Content.aspx?PageID=53>.

<sup>8</sup> <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf><sup>9</sup>, “HAART, CD4 $<200$ ”  
(<http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>)

<sup>10</sup> Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services. December 1, 2007; p. 9. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed December 12, 2007.

<b>Performance Measure:</b> Medical Visits	<b>OPR-Related Measure:</b> Yes <a href="http://www.hrsa.gov/performance/performancereview/measures.htm">www.hrsa.gov/performance/performancereview/measures.htm</a>
Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year	
<b>Numerator:</b>	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges <sup>1</sup> , i.e. MD, PA, NP, in an HIV care setting <sup>2</sup> two or more times at least 3 months apart during the measurement year
<b>Denominator:</b>	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year
<b>Patient Exclusions:</b>	1. Patients newly enrolled in care during last six months of the year
<b>Data Element:</b>	1. Is the client HIV-infected? (Y/N) a. Did the client have at least 2 medical visits in an HIV care setting during the reporting period? (Y/N) i. If yes, list the quarters of these visits
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Ryan White Program Data Report, Section 5, Items 42 and 43 may provide data useful in establishing a baseline for this performance measure</li> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic data base</li> <li>• HIVQUAL reports on this measure for grantee under review</li> <li>• Medical record data abstraction by grantee of a sample of records</li> </ul>
<b>National Goals, Targets, or Benchmarks for Comparison</b>	None available at this time.
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"> <li>◦ Rate of HIV-related hospitalizations in the measurement year</li> <li>◦ Rate of HIV-related emergency room visits in the measurement year</li> <li>◦ Rate of opportunistic infections in the measurement year</li> <li>◦ Mortality rates</li> </ul>
<b>Basis for Selection and Placement in Group 1:</b>	
<p>Clinicians should schedule routine monitoring visits at least every 4 months for all HIV-infected patients who are clinically stable.<sup>3,4</sup></p> <p>Greater experience among primary care physicians in the care of persons with AIDS improves survival.<sup>5</sup></p> <p>Measure reflects important aspects of care that significantly impacts mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.</p>	

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**US Public Health Service Guidelines:**

In general, patients with early-stage disease are seen at 3-month intervals to undergo routine medical evaluation and monitoring of CD4 T-cell count, viral load and CBC. During the initial evaluation more frequent visits are common because there is so much information to transmit. Visits should also be more frequent when therapy is introduced and when the CD4 T-cell count is <200 cells/mm<sup>3</sup> because complications are more likely.<sup>6</sup>

Multiple studies have demonstrated that better outcomes are achieved in patients cared for by a clinician with expertise. This has been shown in terms of mortality, rate of hospitalizations, compliance with guidelines, cost of care, and adherence to medications. The definition of expertise in these studies has varied, but most rely on the number of patients actively managed. Based on this observation, the Panel recommends HIV primary care by a clinician with at least 20 HIV-infected patients and preferably at least 50 HIV-infected patients. Many authoritative groups have combined the recommendation based on active patients, along with fulfilling ongoing CME requirements on HIV-related topics.<sup>7</sup>

**References/Notes:**

Guidelines state that routine monitoring of HIV-infected patients should occur at least every 3-4 months depending on the stage of the disease.<sup>7</sup> The timeframe of 6 months was determined by clinical expert consensus for the purpose of this measure, but CD4 T-cell counts can and should be measured at more frequent intervals if needed.

<sup>1</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.

<sup>2</sup> An HIV care setting is one which received Ryan White HIV/AIDS Treatment Modernization Act of 2006 funding to provide HIV care and has a quality management program in place to monitor the quality of care addressing gaps in quality of HIV care.

<sup>3</sup> New York State Department of Health. Primary care approach to the HIV-infected patient. New York: New York State Department of Health; 2004. p. 8.

<http://www.hivguideliens.org/Content.aspx?pageID=257>[Accessed November 27, 2007].

<sup>4</sup> AETC National Resource Center. Clinical Manual for Management of the HIV-Infected Adult [http://www.aidsetc.org/pdf/AETC-CM\\_071007.pdf](http://www.aidsetc.org/pdf/AETC-CM_071007.pdf) [Accessed November 27, 2007].

<sup>5</sup>Kitahata MM, Van Rompaey SE, Dillingham PW, Koepsell TD, Deyo RA, Dodge W, Wagner EH. Primary care delivery is associated with greater physician experience and improved survival among persons with AIDS. *J Gen Intern Med.* 2003 Feb;18(2):157-8.

<sup>6</sup> Bartlett JG, Cheever LW, Johnson MP, Paauw DS [eds]. A Guide to Primary Care of People with HIV/AIDS. Rockville(MD): US Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; 2004, p. 167. <http://hab.hrsa.gov/tools/primarycareguide/>. [Accessed

November 27, 2007]. <sup>7</sup> Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services. December 1, 2007; 1-143. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed December 12, 2007.

<b>Performance Measure:</b> PCP Prophylaxis	<b>OPR-Related Measure:</b> Yes <a href="http://www.hrsa.gov/performance/performancereview/measures.htm">www.hrsa.gov/performance/performancereview/measures.htm</a>																				
Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm <sup>3</sup> who were prescribed PCP prophylaxis																					
<b>Numerator:</b>	Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm <sup>3</sup> who were prescribed PCP prophylaxis																				
<b>Denominator:</b>	Number of HIV-infected clients who: <ul style="list-style-type: none"> <li>• had a medical visit with a provider with prescribing privileges<sup>1</sup>, i.e. MD, PA, NP at least once in the measurement year, and<sup>3</sup></li> <li>• had a CD4 T-cell count below 200 cells/mm<sup>3</sup></li> </ul>																				
<b>Patient Exclusions:</b>	1. Patients with CD4 T-cell counts below 200 cells/mm <sup>3</sup> repeated within 3 months rose above 200 cells/mm <sup>3</sup> 2. Patients newly enrolled in care during last three months of the measurement year																				
<b>Data Element:</b>	1. Is the client HIV-infected? (Y/N) <ul style="list-style-type: none"> <li>a. If yes, was the CD4 T-cell count &lt;200 cells/mm<sup>3</sup>? (Y/N)                         <ul style="list-style-type: none"> <li>i. If yes, was PCP prophylaxis prescribed? (Y/N)                                 <ul style="list-style-type: none"> <li>1. If no, was the CD4 count repeated within 3 months? (Y/N)   <ul style="list-style-type: none"> <li>a. If yes, did it remain below 200 cells/mm<sup>3</sup>? (Y/N)   <ul style="list-style-type: none"> <li>i. If yes, was PCP prophylaxis prescribed? (Y/N)</li> </ul> </li> </ul> </li> </ul> </li> </ul> </li> </ul>																				
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic data base</li> <li>• HIVQUAL reports on this measure for grantee under review</li> <li>• Medical record data abstraction by grantee of a sample of records</li> </ul>																				
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	IHI Goal: 95% <sup>2</sup> National HIVQUAL Data <sup>3</sup> : <table border="1" data-bbox="516 1266 1242 1413"> <thead> <tr> <th></th> <th>2003</th> <th>2004</th> <th>2005</th> <th>2006</th> </tr> </thead> <tbody> <tr> <td>Top 10%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Top 25%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Median*</td> <td>93.3%</td> <td>90.9%</td> <td>92.3%</td> <td>94.4%</td> </tr> </tbody> </table> *from HAB data base		2003	2004	2005	2006	Top 10%	100%	100%	100%	100%	Top 25%	100%	100%	100%	100%	Median*	93.3%	90.9%	92.3%	94.4%
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Top 25%	100%	100%	100%	100%																	
Median*	93.3%	90.9%	92.3%	94.4%																	
<b>Outcome Measures for Consideration:</b>	<ul style="list-style-type: none"> <li>◦ Rate of PCP in the measurement year</li> <li>◦ Mortality rates</li> <li>◦ Cost savings</li> </ul>																				

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**Basis for Selection and Placement in Group 1:**

Pneumocystis pneumonia (PCP) is the most common opportunistic infection in people with HIV. Without treatment, over 85% of people with HIV would eventually develop PCP. It is a major cause of mortality among persons with HIV infection, yet is almost entirely preventable and treatable. Pneumocystis almost always affects the lungs, causing a form of pneumonia. People with CD4 T-cell counts under 200

<sup>3</sup> cells/mm are at greatest risk of developing PCP. The drugs now used to prevent and treat PCP include TMP/SMX, dapsone, pentamidine, and atovaquone.<sup>4</sup>

Before the widespread use of primary PCP prophylaxis and effective ART, PCP occurred in 70%--80% of patients with AIDS. The course of treated PCP was associated with a mortality rate of between 20% and 40% in persons with profound immunosuppression. Approximately 90% of cases occurred among patients with CD4 T-cell counts <200 cells/mm<sup>3</sup>.<sup>5</sup>

Measure reflects important aspect of care that significantly impacts survival and mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.

**US Public Health Service Guidelines:**

HIV-infected adults and adolescents, including pregnant women and those on HAART, should receive chemoprophylaxis against PCP if they have a CD4 T-cell count <200 cells/mm<sup>3</sup>.<sup>6</sup>

**References/Notes:**

<sup>1</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.

<sup>2</sup> IHI Measure reads, “Percent of Patients with a CD4 Cell Count Below 200 cells/mm<sup>3</sup> Receiving Pneumocystis Carinii Pneumonia (PCP) Prophylaxis”

<sup>3</sup> (<http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>)

<sup>4</sup> [http://www.aidsinfonyet.org/factsheet\\_detail.php?fsnumber=515](http://www.aidsinfonyet.org/factsheet_detail.php?fsnumber=515)

<sup>5</sup> Centers for Disease Control and Prevention. Treating opportunistic infections among HIV-infected adults and adolescents: recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America. MMWR 2004;53(No. RR-15) (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5315a1.htm>)

<sup>6</sup> Centers for Disease Control and Prevention. Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons — 2002 Recommendations of the U.S. Public Health Service and the Infectious Diseases Society of America. MMWR 2002;51 (No. RR-8) (<http://www.cdc.gov/mmwr/PDF/rr/rr5108.pdf> or <http://aidsinfo.nih.gov/ContentFiles/OIpreventionGL.pdf>)

**\*ATTACHMENT:** 2000 Ryan White CARE Act Law Requirements (*the following was updated using the unofficial compilation of the Ryan White CARE Act, which includes the provisions of P.L. 109-415 signed December 19, 2006.* Abstracted from PDF File-www.HRSA.gov/hab

(e) REQUIREMENTS REGARDING IMPOSITION OF CHARGES FOR SERVICES.-

(1) IN GENERAL.-The Secretary may not make a grant under this part unless, subject to paragraph (5), the applicant for the grant agrees that-(A) in the case of individuals with an income less than or equal to 100 % of the official poverty line, the provider will not impose charges on any such individual for the provision of services under the grant;

(B) in the case of individuals with an income greater than 100 % of the official poverty line, the provider-

(i) will impose charges on each such individual for the provision of such services; and

(ii) will impose charges according to a schedule of charges that is made available to the public;

(2) LIMITATION ON CHARGES REGARDING INDIVIDUALS SUBJECT TO CHARGES. – With respect to the imposition of a charge for purposes of paragraph (1) (B) (ii), the Secretary may not make a grant under this part unless, subject to paragraph (5), the applicant for the grant agrees that-

(A) in the case of individuals with an income greater than 100 % of the official poverty line and not exceeding 200 % of such poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 5 percent of the annual gross income of the individual involved;

(B) in the case of individuals with an income greater than 200 % of the official poverty line and not exceeding 300 % of such poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 7 % of the annual gross income of the individual involved; and

(C) in the case of individuals with an income greater than 300 % of the official poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 10 % of the annual gross income of the individual involved.

(2) ASSESSMENT OF CHARGE.-With respect to compliance with the assurance made under paragraph (1), a grantee under this part may, in the case of individuals subject to a charge for purposes of such paragraph-

(A) assess the amount of the charge in the discretion of the grantee, including imposing only a nominal charge for the provision of services, subject to the provisions of such paragraph regarding public schedules regarding limitation on the maximum amount of charges; and

(B) take into consideration the medical expenses of individuals in assessing the amount of the charge, subject to such provisions.

(4) APPLICABILITY OF LIMITATION ON AMOUNT OF CHARGE.-The Secretary may not make a grant under section 2611 unless the applicant of the grant agrees that the limitations established in subparagraphs (C), (D), and (E) of paragraph (1) regarding the imposition of charges for services applies to the annual aggregate of charges imposed for such services, without regard to whether they are characterized as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges.

(5) WAIVER.-

(A) IN GENERAL.-The State shall waive the requirements established in paragraphs (1) through (3) in the case of an entity that does not, in providing health care services, impose a charge or accept reimbursement from any third-party payor, including reimbursement under any insurance policy or under any federal or state health benefits program.

(B) DETERMINATION.-A determination by the State of whether an entity referred to in subparagraph (A) meets the criteria for a waiver under such subparagraph shall be made without regard to whether the entity accepts voluntary donations regarding the provision of services to the public.

## Appendix F: Ryan White HIV/AIDS Treatment Extension Act of 2009 Definitions for Eligible Services

### Core Medical Services

Core medical services are a set of essential, direct health care services provided to persons living with HIV/AIDS and specified in the Ryan White HIV/AIDS Treatment Extension Act of 2009.

- a. ***Outpatient/ambulatory medical care (health services)*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe Antiretroviral (ARV) therapy in an outpatient setting. Settings include clinics, medical offices and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's (PHS) guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
  - See Section 3, page 4 for AOMC description from HRSA/HAB Division Service Systems Monitoring Standards FAQ April 2011.
- b. ***AIDS Drug Assistance Program (APA, not ADAP)*** are local pharmacy assistance programs implemented by Part A, B or C Grantee or a Part B consortium to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g. primary care or case management) to the clients that they serve through Ryan White HIV/AIDS Program contract with their grantee.

Programs are considered APAs if they provide HIV/AIDS medications to clients and meet all of the following criteria:

- Have client enrollment process;
- Have uniform benefits for all enrolled clients;
- Have a record system for distributed medications; and
- Have a drug distribution system.

Programs are not APAs if they dispense medications in one of the following situations:

- As a result or component of a primary medical visit;
- On an emergency basis (defined as a sing occurrence of short duration); or
- By giving vouchers to a client to procure medications.

Local APAs are similar to AIDS Drug Assistance Programs (ADAPs) in that they provide medications for the treatment of HIV disease. However, local APAs are not paid for with Part B funds "earmarked" for ADAP.

- c. **Oral health care** includes diagnostic, preventive and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and other trained primary care providers.
  - d. **Early intervention services for Parts A and B** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency and tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
  - e. **Health insurance premium and cost sharing Assistance** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments and deductibles.
  - f. **Home health care** includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing and other medical therapies.
  - g. **Home and Community-based health services** includes skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include: durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental and rehabilitation services.
- NOTE: Inpatient hospitals services, nursing home and other long term care facilities are not included as home and community-based health services.

- h. **Hospice services** are end-of-life care provided to clients in the terminal stage of an illness. It includes room, board, nursing care, counseling, physician services and palliative therapeutics. Services may be provided to clients in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services.
- i. **Mental health services** are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists and licensed clinical social workers.
- j. **Medical nutrition therapy** is provided by a licensed registered dietitian outside of a primary care visit. The provision of food, nutritional services and nutritional supplements may be provided

pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician.

Nutritional services not provided by a licensed, registered dietician shall be considered a support service. Food, nutritional services and supplements not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician also shall be considered a support service.

- k. *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 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 reevaluation 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.
- l. *Substance abuse services (outpatient)*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel.

### **Support Services**

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.

- m. *Case management services (non-medical)*** include 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.
- n. *Child care services*** are the provision of care for the children of clients who are HIV-positive while the clients are attending medical or other appointments or RWHAP-related meetings, groups or training. This does not include child care while a client is at work.
- o. *Pediatric developmental assessment and early intervention services*** are 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.

NOTE: Only Part D programs are eligible to provide developmental assessment and early intervention services.

- p. **Emergency financial assistance** is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers and food stamps) and medication when other resources are not available. Part A and Part B programs must allocate, track and report these funds under specific service categories as described under 2.6 in the Division of Service Systems Program Policy Guidance No. 2 (formally Policy No. 97-02).
- q. **Food bank/home-delivered meals** are the provision of actual food or meals. It does not include finances to purchase food or meals but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies, should be included in this item.
- r. **Health education/risk reduction** is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients with HIV improve their health status.
- s. **Housing services** are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care or assisted living residential services.
- t. **Legal services** are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program.

NOTE: Legal services do not include any legal services to arrange for guardianship or adoption of children after the death of their normal caregiver.

- u. **Linguistics services** include the provision of interpretation and translation services, both oral and written.
- v. **Medical transportation services** are conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Medical transportation is classified as a support service and is used to provide transportation for eligible Ryan White HIV/AIDS Program clients to core medical services and support services.

Medical transportation must be reported as a support service in all cases, regardless of whether the client is transported to a medical core service or to a support service.

- w. **Outreach services** are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status (i.e., case finding) so that they may become aware of, and may be enrolled in care and treatment services. Outreach services do not include HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.
- x. **Permanency planning** is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
- y. **Psychosocial support services** are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.
- aa. **Referral for health care/supportive services** are the act of directing a client to a service in person or through telephone, written or other type of communication. Referrals for health care/supportive services that were not part of ambulatory/outpatient medical care services or case management services (medical or non-medical) should be reported under this item. Referrals for health care/supportive services provided by ambulatory/outpatient medical care providers should be included under ambulatory/outpatient medical care service category. Referrals for health care/supportive services provided by case managers (medical or non-medical) should be reported in the appropriate case management service category, Medical case management or Case management (non-medical).
- ab. **Rehabilitation services** are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology and low-vision training.
- ac. **Respite care** is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.
- ad. **Substance abuse services (residential)** are the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

NOTE: Part C programs are not eligible to provide substance abuse services (residential).

- ae. *Treatment adherence counseling* is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

## Appendix G: Units of Service - Definitions

SERVICE CATEGORY	UNITS OF SERVICE
Ambulatory/Outpatient Care	1 visit
Drug Reimbursement Program	1 prescription for up to 30 days of medications <sup>1</sup>
Health Insurance Premium & Cost Sharing Assistance	1 premium <sup>2</sup>
Home Health Care	1 visit <sup>3</sup>
Home and Community-Based Health Services	1 visit
Oral Health	1 visit
Hospice Services	1 day - home or residential
Mental Health Services	1 visit 1 individual or group encounter
Medical Nutrition Therapy	1 visit or 1 case of supplement <sup>4</sup>
Rehabilitation Services	1 visit
Substance Abuse Services	1 day of residential treatment 1 individual or group encounter
Treatment Adherence Counseling	1 individual or group encounter <sup>5</sup>
Child Care Services	1 child care session
Emergency Financial Assistance	1 assistance voucher or assistance payment
Medical Case Management	1 Medical Case Mgr. encounter per client per day <sup>6</sup>
Case Management (non-medical)	1 Non-medical Case Mgr. encounter per client per day <sup>5</sup>
Psychosocial Support Services	1 individual or group encounter
Respite Care	1 session of respite care
Early Intervention Services	1 visit 1 client encounter
Food Bank/Home Delivered Meals	1 meal/bag/gift card or voucher <sup>7</sup>
Health Education/Risk Reduction	1 individual or group encounter <sup>8</sup>
Housing Assistance	1 day of housing 1 housing related service
Legal services	1 client encounter 1 individual or group encounter
Outreach Services	1 client contact 1 individual or group encounter <sup>7</sup>
Linguistic Services	1 individual or group encounter
Referral to health care/support services	1 client contact
Medical Transportation	1 one round trip or medical transportation voucher <sup>9</sup>

<sup>1</sup> The unit of service is one prescription for up to 30 days of medication. A prescription written for less than 30 days is counted as one unit. If a prescription is written for more than 30 days, the number of units is the number of days of the prescription divided by 30. Units of service should be reported as whole numbers. For example, a prescription is written for 90 days. The units of service are 90 divided by 30 equals 3 units of service ( $90/30=3$ ). If a prescription is written for 40 days, 40 divided by 30 equals 1.3 for 2 units of service ( $40/30=1.3$  for 2 units) Any prescription that is for less than one full month should be rounded up to the next whole number for the units of service.

<sup>2</sup> The unit of service is one premium, deductible or co-pay.

<sup>3</sup> The unit of service is one visit by a health care professional to a client's home per day. For example, if a nurse visits a client, begins a medical therapy, leaves and comes back to the client's home that same day, that is counted as one unit of service. If a different medical professional visits the same client on the same day as the nurse, that visit is counted as a second unit of service.

<sup>4</sup> The unit of service is one visit to a licensed registered dietician outside of a primary care visit or one case of a nutritional supplement such as Boost or Ensure.

<sup>5</sup> The unit of service for individual clients is the unduplicated number of clients seen in one day for Treatment Adherence Counseling. For group encounters, one unit is the number of groups receiving the counseling in one day. For example, a presentation on adherence before a support group is one unit of service.

<sup>6</sup> The unit of service is the number of unduplicated clients seen for this service per day. For example, a medical case manager meets with a client and gives them treatment adherence counseling and a referral to a social service agency. On that same day, the case manager telephones the client to ask if the client made an appointment with the social service agency. All those activities on the part of the case manager are counted as **one** unit of service for that client.

<sup>7</sup> Depending on how the program operates, a unit of service will be one meal, one bag or box of food and/or essential household supplies or a gift card or voucher to a grocery store.

<sup>8</sup> The unit of service for an individual encounter is the number of unduplicated individuals contacted per day. The individual is counted as **one** unit of service, not the number of condoms or pieces of literature distributed.

<sup>9</sup> The unit of service is one round trip taxi ride, bus trip or other form of transportation per day. For example, if a client is given a bus pass that is good for one week, the client has been given seven units of service.

HIV/AIDS Eligibility File Review Form

Reviewer: \_\_\_\_\_ Date of Review: \_\_\_\_\_ Agency: \_\_\_\_\_ Contract # \_\_\_\_\_ Funding \_\_\_\_\_

This form is to be completed for eligibility client file reviews. Dates should be added where appropriate; those items are noted by this sign \* in the Y/N box. For example, a date may need to be added for the six month recertification form. Additional comments can be added in the comment boxes or on the last page. Any corrective action for files can also be added on the last page.

	Client #						
<b>Required documentation within client file includes:</b>	Y/N						
*DH 3203 Authorization to Disclose Confidential information <i>(or similar local form)</i>							
*DH 3204 Initiation of Services <i>(or similar local form)</i>							
*DH 2116 Consent to fax <i>(optional)</i>							
*Eligibility Application signed and dated by client <i>(one time only at initial application unless file was closed for more than one year)</i>							
<b>Required Worksheets:</b>	Y/N						
*Eligibility Staff Assessment Worksheet <i>(only needed once during first application by client unless file was closed for more than one year)</i>							
*Six Month Recertification Review Form - Is there a current (not > 6 months) form showing no change or that there has been a change?							
If there is a change, is there current documentation?							
<i>No change</i>							
<i>Third part payer (Medicaid, Medicare, Private Insurance, Veterans benefits)</i>							
<i>Income (current pay stubs, recent award letter)</i>							
<i>Living in Florida (utility bill, lease, drivers license)</i>							

**Comments:**

HIV/AIDS Eligibility File Review Tool

	Client #						
<b>Proof of HIV - Which of the following documentation was used to provide proof of HIV-positivity?</b>	Y/N						
<i>A confirmed positive HIV antibody test result (Reactive EIA/ELISA screening test) confirmed by Western Blot or Immunofluorescence Assay (IFA) or Nucleic Acid Testing (Aptima) by blood, oral fluid or urine.</i>							
<i>A positive HIV direct viral test such as PCR or P24 antigen.</i>							
<i>A positive viral culture result.</i>							
<i>A detectible HIV Viral Load or viral resistance test result.</i>							
<b>If this is an exposed infant is there documentation of:</b>							
<i>Mother's status.</i>							
<i>Infant's status if above the age of 12 months.</i>							
<b>Living in Florida – Which of the following was used as proof of living in Florida? (keep in mind there should be a photo ID when possible, but also another form of proof if circumstances warrant it as photo ID is not always accurate)</b>	Y/N						
<i>Photo ID (describe)</i>							
<i>Other forms of ID: check all that apply</i>							
<i>Utility bill with name and address</i>							
<i>Mortgage or rent agreement with name and address</i>							
<i>Statement of support letter from family or friend</i>							
<i>Letter from homeless shelter or social service agency</i>							
<i>Current voter registration card</i>							
<i>US Visa Immigrant or Nonimmigrant</i>							
<i>Prison records (if recently released)</i>							
<i>Unemployment documentation with address</i>							
<i>Other (describe)</i>							
<b>Is the social security number provided?</b>							
<b>If the client has no social security number, was an alternate identification number created appropriately? (see eligibility manual for creating the number)</b>							

HIV/AIDS Eligibility File Review Tool

	Client #						
<b>Income and Verification</b>	<b>Y/N</b>						
Did the client meet the income waiver criteria? <i>(see determining income waiver in manual)</i>							
If yes, what documentation was used to make this determination?							
<i>Medicaid (copy of card is not sufficient, must be a current Medicaid check from FLMISS or other source)</i>							
<i>Project AIDS Care (current level of care)</i>							
<i>Food Stamps (letter)</i>							
<i>Supplemental Security Income (SSI)</i>							
<i>Special Low Income Medicare Beneficiary (SLIMB)</i>							
<i>Qualified Medicare Beneficiary (QMB)</i>							
<i>Low Income Subsidy (LIS or Extra help)</i>							
<i>Temporary Assistance for Needy Families (TANF)</i>							
<i>Women, infant and Children (WIC)</i>							
<i>Local Indigent Program</i>							
<i>Other (describe)</i>							
If the client does not meet the income waiver, what documentation was used to provide proof of income?	<b>Y/N</b>						
<i>Paystubs</i>							
<i>Self-Employment documentation - List type</i>							
<i>Letter of Support (if no income explain)</i>							
<i>1040 or W2 form</i>							
<i>Retirement Income</i>							
<i>Military/Veteran Pension</i>							
<i>A recent Third Party Query (TPQY)</i>							
<i>Unemployment</i>							
<i>Alimony</i>							
<i>Survivors benefits (from children)</i>							
<i>Child Support</i>							

<i>Other (describe)</i>							
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**HIV/AIDS Eligibility File Review Tool**

	Client #						
<b>Income and Verification Continued</b>	<b>Y/N</b>						
Was gross income counted? <i>(before taxes taken out; if net income was counted, then calculation is wrong)</i>							
Was household size calculated correctly? <i>(applicant, children in household, married, adults with comingled funds)</i>							
Was the income counted correctly? <i>(see how to calculate in the eligibility manual based on how often the person gets paid)</i>							
Was FPL calculated correctly? <i>(see how to calculate in the eligibility manual)</i>							
<b>Screening for other Programs</b>	<b>Y/N</b>						
Is there evidence that client was eligible for payer sources listed below?							
<b>* Private insurance</b> <i>(were pay stubs reviewed to determine possible deductions, is person employed and if so was documentation provided by employer about available insurance)</i>							
<b>* Medicare</b> <i>(is client receiving disability for past two years, was LIS applied for through SSA.gov, does client have Part D)</i>							
<b>* Medicaid</b> <i>(was the pre-screening completed and a print out in file, was a Medicaid verification done through FLMMIS or other program)</i>							
<b>* Medicaid PAC</b> <i>(was client reviewed for possible eligibility)</i>							
<b>* Veterans Administration</b> <i>(is client eligible and were they informed of benefits available from VA)</i>							
<b>Children's Medical Services</b> <i>(is child under 21)</i>							
<b>Local Assistance Program</b> <i>(describe)</i>							
<i>Other (describe)</i>							
<b>Comments:</b>							

**HIV/AIDS Eligibility File Review Tool**

	Client #						
<b>Eligibility Determination</b>	Y/N						
*Was the client determined eligible and a Notice of Eligibility issued?							
*Was the client determined ineligible? If yes,							
<i>Was a notice of ineligibility provided?</i>							
<i>Was a notice of rights provided?</i>							
*Was an exception request submitted? If yes,							
<i>Was the exception request form completed?</i>							
<i>Was the form signed by all appropriate parties? (supervisor, lead agency, contract manager, HAPC, etc)</i>							
<b>Services</b>	Y/N						
If there were gap's in the client's eligibility, did the client receive services that were paid for by this funding source during that period?							
<b>CAREWare</b>	Y/N						
Is all documentation scanned into CAREWare under the attachments section?							
<i>Application?(for al new clients)</i>							
<i>Proof of HIV?</i>							
<i>Proof of Living in Florida (or county specific for Part A)?</i>							
<i>Proof of Income?</i>							
<i>Proof of third party insurance? (including Medicaid pre-screening if applicable)</i>							
<i>Signed and dated Notice of Eligibility?</i>							
<i>Other? Describe.</i>							

**Comments:**

## CAREWARE DATA ENTRY REQUIREMENTS

### Purpose

The purpose of this attachment is to identify the information that must be captured and entered into CAREWare. Providers should ensure patient care services paid for by Ryan White Part B, Patient Care Network, and General Revenue are entered into the CAREWare system for reporting purposes. In addition, this attachment provides information on how the collected data must be entered to ensure data consistency and integrity.

*Please see the Florida HIV/AIDS Eligibility Procedures Manual for eligibility requirements. HOPWA CAREWare data entry requirements are provided in a separate document.*

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### Required Information in the DEMOGRAPHICS TAB

Demographic information must be collected for **all** eligible clients seeking patient care services by the person determining eligibility, regardless of whether or not the client actually receives a service. Demographic information must include the following, at a minimum:

1. Legal First Name (any alias or nickname belongs in Common Notes)
  2. Middle Name (if applicable)
  3. Legal Last name
  4. Date of Birth (mm/dd/yy)
  5. Gender (including Transgender subgroup)
  6. Ethnicity
  7. Race
  8. Address
  9. City
  10. State
  11. Zip Code
  12. County
  13. Phone Number (if applicable) (include dashes)
  14. HIV Status
  15. HIV+ Date
  16. AIDS Date (if applicable)
  17. HIV risk factors (please note: currently this field can not be uploaded from HMS)
-

**Required  
Information in  
the SERVICE  
TAB**

For any patient care service paid for by Ryan White Part B, Patient Care Network, General Revenue, or State HOPWA

1. Year (select year of service)
2. Vital Status
3. Deceased Date (if applicable)
4. Enrl Status
5. Enrl Date
6. Case Closed (if applicable)
7. Add/Edit Service Details
  - a. Date
  - b. Service Name
  - c. Contract (current Contract)
  - d. Units

The following fields apply to AICP (AIDS Insurance Continuation Program) only:

1. HIP Enrl Status
2. HIP Enrl Date
3. HIP Closed

**Required  
Information in  
the ANNUAL  
REVIEW TAB**

Review and update at every eligibility determination.

1. Primary Insurance
2. Other Insurance
3. Household Income
4. Household Size
5. Poverty Level (will populate automatically)
6. Primary HIV Medical Care
7. Housing/Living Arrangement

For any client receiving Ambulatory/Outpatient Medical Care services (paid for by Ryan White Part B, Patient Care Network, or General Revenue) complete the questions below:

8. Was client counseled about HIV transmission risks?
9. Who counseled about transmission risks?
10. Was client screened for mental health?
11. Was client screened for substance abuse?

**Required  
Information in  
the  
ENCOUNTERS  
TAB**

Create an encounter, as appropriate, for any client receiving Ambulatory/Outpatient Medical Care services and/or Medical Case Management services (paid for by Ryan White Part B, Patient Care Network, or General Revenue) added on the service tab of CAREWare.

**1. Vital Signs Sub-Tab** (For female clients who are pregnant or delivered within the calendar year.)

Select View/Edit History

Add data for the following fields

- a. Estimated Conception Date
- b. Prenatal Begin Date
- c. # Prenatal Visits
- d. Delivery/Outcome Date
- e. HIV Status of Newborn
- f. Pregnancy Outcome
- g. ART Counseling?
- h. ART Offered?
- i. ART Taken?
- j. ART Date?

**2. Medications Sub-Tab**

- a. HIV-associated medications including ARVs, OIs, or other
- b. Units, Form, Strength, Frequency, Indication, and OI condition, if applicable
- c. Every time medication is prescribed complete as applicable: Start, Stop, Correct Data Error, or Change Dose

**3. Labs Sub-Tab**

Current Test and Result (CD4 and Viral Load) for every lab test

**4. Screening Labs Sub-Tab**

Current Test, Result, Titer and Treatment for Syphilis, if applicable

**5. Screening Sub-Tab**

Current Test, Current Result, Current Action and Current Score for the following screenings, as applicable: Annual TB Screening, Paps

**6. Immunizations Sub-Tab**

As applicable: Hep B, Hep C

**Required Information in the UNIQUE ID TAB**

1. Select the "Attachments" hyperlink to upload:
  - a. Proof of living in Florida
  - b. Proof of identity
  - c. Verification of income
  - d. Proof of HIV
  - e. Proof the program is payer of last resort
  - f. Signed Application

- 
- g. Signed Notice of Eligibility (every time eligibility is renewed)
  - h. Signed Notice of Ineligibility (if applicable)
  - 2. Medicaid # no dashes (if applicable)
  - 3. Medicare # include dashes (###-##-####) (if applicable)
  - 4. PAC # no dashes (if applicable)
  - 5. Social Security # include dashes (###-##-####)  
(If client has no social security number please use the alternate identification number formula outlined in Section 8 of the Florida HIV/AIDS Eligibility Procedures Manual.)
  - 6. Date Eligibility Expires
  - 7. Key Points of Entry
- 

**Required  
Information in  
the FORMS TAB**

- 1. Eligibility Staff Assessment Worksheet (One time only unless the client file is closed for a period of a year or more, then a new application should be completed.)
- 2. Insurance Waiver Form (if applicable)
- 3. Notice of Eligibility or Ineligibility (every six months)
- 4. Six Month Recertification (every six months)

All forms are custom sub forms. This means these forms are kept each time they are completed and will provide a history over time. You must check the box in the top left corner of the form to fill it in and save.

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## FLORIDA DEPARTMENT OF HEALTH, HIV/AIDS AND HEPATITIS SECTION CLIENT COMPLAINT, GRIEVANCE, AND APPEAL PROCEDURES

### Introduction

The following procedures apply to programs operated under the auspices of the Florida HIV/AIDS and Hepatitis Section including, but not limited to, Ryan White Part B, Patient Care Network, Housing Opportunities for Persons With AIDS (HOPWA) or patient care general revenue funded services for eligible, enrolled clients only. This document is intended to guide lead agencies/project sponsors and/or providers in developing and refining their own grievance policies and procedures, and is not intended for distribution to clients. However, local policies and procedures must contain the following core elements at a minimum:

- Fair and reasonable written procedures that promote resolutions at the local level.
- Procedures that ensure clients are aware of their right to file a formal grievance or appeal, including posting the right of a client to file a grievance or appeal in a prominent place and written notices that include the right to file a grievance or appeal in other languages to meet the needs of clients with limited English proficiency.
- Staff training on grievance and appeal procedures by local agency staff.
- Specific timeframes for resolving complaints, grievances and appeals. All complaints should be acknowledged within two (2) business days and resolved within ten (10) business days. Both grievances and appeals should be resolved by the lead agency within sixty (60) calendar days of the date of the grievance or appeal, and the lead agency must notify the client in writing of the decision.
- Final review by an independent third party when the grievance or appeal can not be resolved to the satisfaction of all parties involved.

### Definitions

- a. A complaint is any verbal or written expression of dissatisfaction by an individual regarding the administration or provision of services. A complaint is an opportunity to resolve a problem without it becoming a formal grievance or appeal.
- b. An action is any denial, limitation, reduction, suspension, or termination of a service.
- c. A grievance expresses dissatisfaction about any matter other than an action.
- d. An appeal is a request for review of an action.
- e. A dismissal is a formal action to cease delivering services and close the case record of an active client.
- f. A service provider is any entity other than the lead agency/project sponsor that provides a service (i.e. subcontracted transportation or case management provider).

### Complaint Procedures

Providers and clients are encouraged to resolve complaints informally at the lowest organizational level possible prior to initiating the formal grievance or appeal procedures.

Complaints received by the service provider/project sponsor:

- Should be acknowledged within two (2) days and resolved within ten (10) business days.
- If the service provider resolves the complaint to the satisfaction of the client, no further action is needed.
- If the service provider can not resolve the complaint to the client's satisfaction within ten (10) business days, the client will have the option to file a formal written grievance or

appeal with the lead agency/project sponsor. If the client is unable to file a grievance or appeal in writing the lead agency/project sponsor will assist the client in doing so.

Complaints received by the lead agency/project sponsor:

- Should be acknowledged within two (2) days and resolved within ten (10) business days.
- If the lead agency/project sponsor provider resolves the complaint to the satisfaction of the client, no further action is needed.
- If the lead agency/project sponsor can not resolve the complaint to the client's satisfaction within ten (10) business days the lead agency/project sponsor will give the client the option to file a formal grievance or appeal in writing. If the client is unable to file a grievance or appeal in writing the lead agency/project sponsor will assist the client in doing so.

### **Grievances and Appeals**

Lead agencies/project sponsors and service providers must ensure that clients are informed of grievance and appeal policies and procedures at the first meeting between the case manager and the prospective client. At a minimum, clients must be reminded of these policies and procedures at every eligibility redetermination. Clients must be told that the documents can also be made available in alternate formats (e.g., foreign languages, Braille) to accommodate the needs of the client as required by contract. Lead agencies/project sponsors should make certain that the contract manager is notified of any grievances and appeals upon receipt.

Information about the grievance and appeal process, and how a client may start the process must be posted in prominent areas such as lobbies or waiting rooms. Grievance and appeal procedures must clearly identify the title of a specific staff position or positions that a client may contact for assistance in initiating the process. Contact information such as phone numbers, e-mails, and mailing addresses must also be clearly provided and should be included in written notices and posted documents.

### **Grievance Procedures**

Grievances received by the service provider:

- Complaints that are not resolved to the client's satisfaction within ten (10) business days, that are not about an action, such as a denial of services, will become a grievance and should be sent to the lead agency/project sponsor for resolution. The service providers must continue to work with the client and the lead agency/project sponsor for resolution.
- The client may file a grievance directly with the lead agency/project sponsor.

Grievances received by the lead agency/project sponsor:

- The lead agency/project sponsor receiving the grievance must enter it into the grievance and appeal log and send a written acknowledgment to the client within five (5) business days of receipt.
- The lead agency/project sponsor is responsible for collecting all pertinent facts from both parties regarding the grievance.
- The individual(s) conducting the final review of a grievance must not be involved in previous levels of review or decision making. Additionally, all decision makers must have expertise in the program requirements involved in each grievance.

- The lead agency/project sponsor will have sixty (60) calendar days to resolve the grievance and notify the client in writing of the decision.
- If the grievance is settled to the client's satisfaction, no additional action is required.
- If the grievance is not settled to the client's satisfaction, the lead agency/project sponsor must notify the HIV/AIDS Program Coordinator (HAPC) and the designated Community Programs Coordinator/State HOPWA Housing Coordinator for the area within five (5) business days to seek a resolution.

Grievances received by the HAPC and Community Programs Coordinator/State HOPWA Housing Coordinator:

- The HAPC and Community Programs Coordinator/ State HOPWA Housing Coordinator will review the grievance and issue a written resolution within ten (10) business days to the lead agency/project sponsor.

### **Appeal Procedures**

Appeals received by the service provider:

Complaints about an action, such as a denial of services, that are not resolved to the client's satisfaction within ten (10) business days will become an appeal and should be sent to the lead agency/project sponsor for resolution. The service providers must continue to work with the client and the lead agency/project sponsor for resolution.

Appeals received by the lead agency/project sponsor:

- The lead agency/project sponsor will receive the appeal and will enter it into the grievance and appeal log and send a written acknowledgment to the client within five (5) days of receipt.
- The lead agency/project sponsor is responsible for collecting all pertinent facts from both parties regarding the appeal.
- The individual(s) conducting the final review of an appeal must not be involved in previous levels of review or decision making. Additionally, all decision makers must have expertise in the program requirements involved in each appeal.
- The lead agency/project sponsor will have sixty (60) calendar days to resolve the appeal and notify the client in writing of the decision.
- If the appeal is settled to the client's satisfaction, no additional action is required; however, if the appeal is not settled to the client's satisfaction, the lead agency/project sponsor must notify the HAPC and the designated Community Programs Coordinator/ State HOPWA Housing Coordinator for the area within five (5) business days to seek a resolution.

Appeals received by the HAPC and Community Programs Coordinator/State HOPWA Housing Coordinator:

The HAPC and Community Programs Coordinator/ State HOPWA Housing Coordinator will review the appeal and issue a written resolution within ten (10) business days to the lead agency/project sponsor.

The following provisions apply only to the state HOPWA Program:

- Active HOPWA clients will receive a continuation of their services following a request for an appeal.
- Clients receiving a continuation of services pending an appeal determination will only receive services up to the time period approved during their initial assessment for meeting program requirements. Clients will not receive HOPWA services in excess of 21 weeks, per federal regulations.

### **Program Dismissal**

The HIV/AIDS and Hepatitis Section recognizes the importance of delivering care to its clients. Program dismissal should be implemented only for serious or persistent violations and after intervening steps have been exhausted. Prior to dismissal, the state program office must be notified in writing and all information related to the dismissal must be submitted to state program staff for review and approval.

Reasons for a dismissal include, but are not limited to:

- Immediate program termination may be warranted in instances of fraud, bribery, threats of violence or any other corrupt or criminal acts in connection with the program. Acts of fraud include providing false statements, misrepresentation, impersonation, or other substantiated fraudulent actions that affect a determination as to the client's eligibility to receive services. Threats of violence include verbal and non-verbal actions that threaten the safety of the client themselves, other clients, staff, landlords, or neighbors of clients receiving HOPWA services.
- A client terminated from the program due to criminal behavior or activity may be readmitted into a program upon submission of court documents demonstrating that the client was acquitted, or cleared, of all charges related to the incident that led to termination. Compelling evidence of changes in circumstances and client behavior may also factor into a client's re-admission into the program after termination. However, readmission shall be contingent upon availability of program funds and the client's program eligibility at the time of a request for re-admission.
- Notice of dismissal must be provided in writing to the client within five (5) business days of the state program office's approval of termination. The notice must be delivered by mail and should include substantiated reasons for dismissal.
- The client who has received a notice of dismissal has the right to initiate an appeal in accordance with policies and procedures outlined in this document.

The following provisions apply only to the state HOPWA Program:

- Individuals found to have manufactured methamphetamine on the premises of federally assisted housing and sex offenders subject to a lifetime registration requirement under a state sex offender registration program are prohibited from receiving HOPWA services per Housing and Urban Development (HUD) statute and regulations.

*Please note: This document shall not supersede state statutes or federal regulations.*



## GRIEVANCE AND APPEAL CLASSIFICATION CODES

PLEASE ENTER THE MOST APPROPRIATE CLASSIFICATION CODE IN COLUMN E  
For Appeals use codes 1-16:

**Appeal for a Denial of the following services:**

1. Case Management (Non-Medical)
2. Ambulatory/Outpatient Medical Care
3. AIDS Pharmaceutical Assistance (Local)
4. Oral Health Care
5. Early Intervention Services
6. Medical Transportation Services
7. Health Insurance Premium/Cost Sharing
8. Home Health Care
9. Mental Health Services – Outpatient
10. Medical Nutrition Therapy
11. Medical Case Management (including treatment adherence)
12. Substance Abuse Services – Outpatient
13. Emergency Financial Assistance
14. Food Bank/Home Delivered Meals
15. Linguistic Services
16. HOPWA

For Grievances use codes 17-25:

**Grievance for dissatisfaction in following areas:**

17. **Service Access** - needed service not available, service operating hours, difficulty with getting through on the phone etc, wait time for scheduling or appointments
18. **Waiting Time** - for appointments and /or services
19. **Personnel-related** - attitude, behavior, availability, competence
20. **Medical Practice** - inappropriate treatment, test inaccuracies, vaccines intervals,
21. **Confidentiality / Information Security** - perceived breaches
22. **Care Coordination** - problems with referrals, duplication, etc.
23. **Safety** - potential risks or actual injuries
24. **Facilities / Maintenance** - temperature complaints, ground conditions, building cleanliness, security, damaged or missing property, etc
25. **Financial** - costs of services, provider reimbursement, fee schedules, lack of funding for adequate coverage, etc.

## Appendix K: CONTACT INFORMATION

**Florida Department of Health**  
**HIV/AIDS and Hepatitis Section**  
 4052 Bald Cypress Way, Bin A09  
 Tallahassee, FL 32399-1715  
 Phone (850) 245-4335  
 FAX: (850) 245-4920  
 Toll-Free: 1-866-560-4927

### HIV/AIDS Patient Care Staff

Program Administration			
Name	Title/Function	Ext.	Email Address
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Tina Waller	Staff Assistant	2516	<a href="mailto:Tina_Waller@doh.state.fl.us">Tina_Waller@doh.state.fl.us</a>

HOPWA			
Name	Title/Function	Ext.	Email Address
Craig Reynolds	State HOPWA Program Coordinator	2539	<a href="mailto:Craig_Reynolds@doh.state.fl.us">Craig_Reynolds@doh.state.fl.us</a>
Cheryl Urbas	State Housing Coordinator	2530	<a href="mailto:Cheryl_Urbas@doh.state.fl.us">Cheryl_Urbas@doh.state.fl.us</a>

Community Programs			
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Uneeda Brewer	Community Programs Coordinator; Areas 1, 3/13, 4, 11A; Eligibility & Case Mgmt Trainings; EC; Contracts	2594	<a href="mailto:Uneeda_Brewer@doh.state.fl.us">Uneeda_Brewer@doh.state.fl.us</a>
Bruce Campbell	Community Programs Coordinator; Areas 2A, 5/6/14, 10; CAG; Peer Programs; Monitoring Tool Development	2540	<a href="mailto:Bruce_Campbell@doh.state.fl.us">Bruce_Campbell@doh.state.fl.us</a>
Meghan Daily	Community Programs Coordinator; Areas 9, 12; PCPG; Comp Plan/SCSN	2522	<a href="mailto:Meghan_Daily@doh.state.fl.us">Meghan_Daily@doh.state.fl.us</a>

Erin Penmann	Community Programs Coordinator; Areas 2B, 15; Web Liaison	2560	<a href="mailto:Erin_Penmann@doh.state.fl.us">Erin_Penmann@doh.state.fl.us</a>
Suzanne Stevens	Community Programs Coordinator; Areas 7, 8, 11B; Medicaid Advisory; Eligibility & Case Mgmt Manuals and Training; Rule Promulgation; AETC Telehealth	2426	<a href="mailto:Suzanne_Stevens@doh.state.fl.us">Suzanne_Stevens@doh.state.fl.us</a>

<b>AIDS Drug Assistance Program (ADAP)</b>			
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Sean-Steven Saint-Fort	Administrative Assistant	2556	<a href="mailto:Sean-Steven_Saint-Fort@doh.state.fl.us">Sean-Steven_Saint-Fort@doh.state.fl.us</a>
Steven Badura	ADAP SW Consultant	2552	<a href="mailto:Steven_Badura@doh.state.fl.us">Steven_Badura@doh.state.fl.us</a>
Vacant	ADAP SW Consultant	2549	
Vacant ADAP	SW Consultant	2537	
Stephanie Brown	ADAP SW Consultant	2551	<a href="mailto:Stephanie_Brown@doh.state.fl.us">Stephanie_Brown@doh.state.fl.us</a>
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Bindu Bhogadi	ADAP IT	N/A	<a href="mailto:Bindu_Bhogadi@doh.state.fl.us">Bindu_Bhogadi@doh.state.fl.us</a>
Stoney Anderson	ADAP IT	N/A	<a href="mailto:Stoney_Anderson@doh.state.fl.us">Stoney_Anderson@doh.state.fl.us</a>
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### **HIV/AIDS Reporting & Information Systems Staff**

<b>Reporting and Information Systems</b>			
<b>Name</b>	<b>Position</b>	<b>Ext.</b>	<b>Email Address</b>
Kate Goodin	Information Systems Development Supervisor & Senior Epidemiologist	4448	<a href="mailto:Kate_Goodin@doh.state.fl.us">Kate_Goodin@doh.state.fl.us</a>
Stacey Lynn	AIMS Development, Training & Support, Needs Assessment, Quality Management	2561	<a href="mailto:Stacey_Lynn@doh.state.fl.us">Stacey_Lynn@doh.state.fl.us</a>
Chris Crouch	CAREWare Reports, Crystal Reports, Report Portal	2525	<a href="mailto:Chris_Crouch@doh.state.fl.us">Chris_Crouch@doh.state.fl.us</a>
Sharon Anderson	Technical Assistance for Patient Care Networks, County Health Department General Revenue, HOPWA, and RSR Ryan White Federal Reporting Requirements	2543	<a href="mailto:Sharon_Anderson@doh.state.fl.us">Sharon_Anderson@doh.state.fl.us</a>

Alex Bello	Project Management	2538	<a href="mailto:Alex_Bello@doh.state.fl.us">Alex_Bello@doh.state.fl.us</a>
Naima Farah	Statistician, Data Integration & Reporting, Data Analysis, and Quality Management	2480	<a href="mailto:Naima_Farah@doh.state.fl.us">Naima_Farah@doh.state.fl.us</a>
Lucretia Jones	Special Projects, CAREWare Support	2535	<a href="mailto:Lucretia_Jones@doh.state.fl.us">Lucretia_Jones@doh.state.fl.us</a>
Haseeb Ahmed	Technical Support & Development, Data Integration & Reporting	2553	<a href="mailto:Haseeb_Ahmed@doh.state.fl.us">Haseeb_Ahmed@doh.state.fl.us</a>
Jeffrey Storm	CAREWare Support, Development & Training, ACCESS Database Development, Maintenance & Reporting	2548	<a href="mailto:Jeffrey_Storm@doh.state.fl.us">Jeffrey_Storm@doh.state.fl.us</a>
Marrissa Walker	AIMS Development, Training & Support, Technical Assistance for RW Grant & RW Federal Reporting	2554	<a href="mailto:Marrissa_Walker@doh.state.fl.us">Marrissa_Walker@doh.state.fl.us</a>