



Patient Care Program Administrative Guidelines

**Ryan White Part B and General Revenue-
Patient Care Network Programs**

Fiscal Year 2014–2015

Patient Care Contract Administrative Guidelines

FY 2014-2015

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Section 1: Introduction

The Florida Department of Health (the 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 (Part B)
- Emerging Communities
- General Revenue Patient Care Network (PCN)
- 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 Part B and PCN contracts. These guidelines and any referenced manuals are updated to provide the most accurate, comprehensive information available. It is the lead agency's responsibility to ensure compliance with all updated guidelines and referenced manuals.

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 Program, 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 Program 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
- Provide and maintain an up-to-date statewide pharmacy formulary addressing the needs of HIV/AIDS patients (this formulary will be forthcoming from the Pharmacy and Therapeutics Committee)
- 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, which includes all guidelines and referenced manuals
- 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 H. 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 the Schedule C. 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) 2.0.

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").

- 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
- 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 (incorporating the following):
 1. Policies and staff training on the requirement that Part B and PCN are the payers of last resort and how that requirement is met
 2. Information on regulations regarding lobbying with federal funds, which should be included in personnel manual and employee orientation
 3. 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
 4. 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
 5. Policies that discourage the use of two charge masters, one for self-pay clients and a higher one for insurance companies
 6. Purchasing policies that discourage kickbacks and referral bonuses per HRSA Universal monitoring standards
 7. Conflict of Interest policy
- Fiscal, programmatic and general policies and procedures that include compliance with federal, Part B and PCN fiscal and programmatic requirements
- 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; these policies and procedures must be consistently implemented
- Policies that forbid the use of Part B and PCN funds for cash payments to service recipients

- Billing and collection, purchasing and procurement and accounts payable and accounting policies and procedures; these policies and procedures must be consistently implemented
- Policies and procedures that acknowledge the revisionary interest of the federal government over property improved or purchased with federal dollars
- Policies and procedures to determine allowable and reasonable costs
- Financial policies and procedures that guide selection of an auditor
- Policies and procedures for handling Part B and PCN revenues including program income
- 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

F. Department of Health 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.

G. 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.

H. Ryan White Part B Care Consortia

According to the current Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87), Section 2613(a)(1), a HIV care consortia is:

An association of one or more public, and one or more non-profit 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 operating within areas determined by the State to be most affected by HIV disease.

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

I. 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.

J. Program References

Listed below are Internet links to resource materials:

- HIV/AIDS and Hepatitis Section (State of Florida): <http://www.floridahealth.gov/diseases-and-conditions/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 Section, Patient Care Policy Notices: <http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/patient-care-program-notices.html>
- Chapter 64D-4, *Florida Administrative Code (F.A.C.)*: <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 I of this guidance for HIV/AIDS and Hepatitis 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, F.A.C.](#) 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 G, 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.

B. Advances

A one-time advance is permissible for PCN and Part B 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.

C. 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 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.
- 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:
 1. Certificate Regarding Lobbying
 2. Financial and Compliance Audit
 3. Civil Rights Checklist
 4. Conflict of Interest
 5. Certificate Regarding Debarment and Suspension
 6. Federal Sub Recipient and Vendor Determination Checklist
 7. IRS form W-9
 8. Ryan White Comprehensive AIDS Resources Emergency Act Contracts/Subcontracts Review Certification
 9. Scrutinized Company Certification (if applicable)
- Lead fiscal agencies are required to provide the contract manager with electronic copies of all subcontracts written for Part B and PCN funds within 60 days of execution. The contract manager will post the subcontract, budget summary, and budget narrative in the contracts folder on the Department's shared drive within 30 days of receipt.

- 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.
- Lead agencies not providing in-house case management are required to competitively procure medical case management and non-medical case management services. This process is based on Department policy, DOHP 250-9-12.

D. 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.

E. 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 AETC medical case management modules are recommended for all new staff and are **required for all** case managers (both medical and non-medical) funded through contracts with the HIV/AIDS and Hepatitis Section. All case managers are required to complete the available modules within 90 days of hire.

- Introduction to Medical Case Management
- Documentation, Progress Notes, and Care Plans
- Understanding Laboratory Values
- HIV Disease Progression
- Preventing Exposure to Opportunistic and Other Infections
- HIV Treatment Guidelines & Antiretroviral Medications Review
- Adherence
- Cultural Competency
- Dealing with Co-Morbid Conditions
- HIV and Nutrition
- HIV Clinical Research Trials
- Legal Issues and HIV

- Mental Health and Illness in the HIV Patient
- Motivational Interviewing
- Resistance to Antiretroviral Therapy
- The Future of HIV Funding Including Ryan White: Economic Constraints and How Do We Adapt?

A pre- and post-test must be completed at the end of each training module. A certificate will be available for all participants. Certificates must be 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 Program 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 Appendix E for Ryan White Program Definitions of Eligible Services.

The 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.

F. Required Data Elements

Lead agencies must ensure that patient care services paid for by Part B, PCN, and General Revenue are entered into the CAREWare system for reporting purposes, in accordance with the CAREWare Data Entry Requirements (see Appendix G).

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>), the [Florida HIV/AIDS Eligibility Determining Procedures Manual](#) and the HRSA monograph, using data to measure public health performance (<http://hab.hrsa.gov/manageyourgrant/files/datatomeasure2010.pdf>).

G. Fee for Service

Co-payments shall be assessed when applicable. If assessed, fees must be reinvested into the HIV program. Refer to the Requirements Regarding Imposition of Charges for Services (Appendix D) 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.

H. Core/Support Service Limitations

The “Food Bank/Home Delivered Meals” line item is limited to \$35.00 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 Part B or PCN clients for service availability and clarification of services.

I. 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 for Florida's HIV care consortia programs can be used for the following purposes and should address these areas of responsibility:

- To provide comprehensive outpatient, essential health and support services for individuals and families infected or affected by HIV 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:

a. Narrative: The Administration total is limited to 10 percent of the total award, with Administration and Clinical Quality Management (CQM) totaling no more than 15 percent. Administrative costs 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.

Administrative costs within the budget may be shifted during the contract period. However, the total dollar amount of Administration 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.

SECTION 3

The information above is required for 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 the Department's Standard Contract, Attachment IV Budget Summary (Attachment 2 for CHDs serving as lead agencies), in the column labeled FY Original Allocation, enter the amount for the fiscal year for each service line item funded. Refer to the Ryan White Program Definitions for Eligible Services (Appendix E) for additional information about direct care services.

Funded service category must include:

a. Service Category: Name the service (i.e.: Case Management Non-Medical)

b. 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.

c. 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.

d. Allocation Methodology: Include information such as basis for expenditure, review process and needs assessment ranking.

e. Additional Guidelines: Include description of guiding principles developed by consortium and other related policies or guidelines.

f. Provider Information: Include the following information for each contracted provider:

- (1) Name and address of provider
- (2) Method of payment
- (3) Funding amount
- (4) Number of clients to be served by agency
- (5) Number of staff in FTEs, if service category allows funding of FTEs
- (6) Additional narrative if necessary

g. 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>).

h. 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 and coordinated access to medically appropriate levels of health and support services, continuity of care and ongoing assessment of the client, consistent with the Ryan White HIV/AIDS Treatment Extension Act of 2009 Definitions for Eligible Services, the Florida [HIV/AIDS Case Management Operating Guidelines](#) and the [Florida Eligibility Procedures Manual](#).”

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

This category can be used to fund case management or eligibility. Indirect costs cannot be included.

3. Clinical Quality Management Budget

CQM will be reimbursed as cost-reimbursement. A maximum of 10 percent of the contract amount may be allocated to CQM activities, with Administration and CQM totaling no more than 15 percent. A narrative description 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.

Please note: 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, Chronic Obstructive Pulmonary Disease (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 Public Health Service (PHS) Clinical Practice Guidelines.

According to HRSA, funding for support services must contribute to positive medical outcomes. Providers must 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 Program Definitions of Eligible Services (see Appendix E) 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>.

The Attachment IV Budget and 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.

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 Bureau of Communicable Diseases, Contract Unit. A 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 Unit via AIMS 2.0
- Bureau of Communicable Diseases, 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 on the Community Programs web page (<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/community-programs.html>). QFRs are submitted according to contract provisions. Contract managers will review at least one QFR with back-up documentation during the contract period to 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 120 days (after receipt of the provider's first QFR) 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 the 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 Contract Unit of the Bureau of Communicable Diseases and the designated 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

The QFR is submitted according to contract provisions. Contract managers will review back-up documentation for the QFR to 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
- Supporting subcontracted providers with technical assistance as needed
- Reviewing and monitoring the data providers are required to enter into CAREWare
- Being familiar with the HRSA Universal, Fiscal and Programmatic monitoring standards, as well as the Ryan White HIV/AIDS Program Part B Manual-Revised 2013
- Participating in area quarterly conference calls
- 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 each subcontract
- Monitoring the lead agency for compliance with the contract and providing the monitoring reports to the Department’s Contract Unit and area Community Programs Coordinator within 20 working days of the monitoring
- 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 Unit (via AIMS 2.0), as outlined in Section 5
- Being familiar with the HRSA Universal, Fiscal and Programmatic monitoring standards, as well as the Ryan White HIV/AIDS Program Part B Manual-Revised 2013
- Participating in area quarterly 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. 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 Section 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.

The HRSA Universal, Fiscal and Programmatic Monitoring Standards have been incorporated into the Patient Care monitoring tools. It is the lead agency and contract manager’s responsibility to be familiar with these standards.

HRSA Universal Monitoring Standards:

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

HRSA Fiscal Monitoring Standards:

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

HRSA Programmatic Monitoring Standards:

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

Ryan White HIV/AIDS Program Part B Manual-Revised 2013:

<http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf>

Section 5: Reporting Requirements

A. Reporting Overview

All HIV/AIDS Patient Care Program 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 adequate data collection systems 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 Unit staff. AIMS 2.0 access and training can be arranged by contacting a member of the Reporting Unit 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 F, "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 3)

Ryan White Part B Consortia and Emerging Communities		
Report Name	Due Date*	Responsible Party
Monthly Expenditure and Reimbursement Report	20 th of each month following the month being reported	Contract Manager and Provider
First Time This Year (FTTY) Report	20 th of each month following the month being reported	Provider
Income/Expenditure Report	20 th of each month	Contract Manager and Provider
Implementation Plan (April 1-March 31 contract year)	Varies by year (Word Document)	Contract Manager and Provider
Revised Implementation Plan (April 1 -March 31 contract year)	Varies by year (Word Document)	Contract Manager and Provider
Provider/Sub-contractor Report (April 1-March 31 of contract year)	May 30 of contract year	Provider
WICY Report (April 1-March 31 contract year)	July 15 of contract year (Word Document)	Provider
Annual Progress Report (April-Final contract year)	July 15 of contract year	Provider

Ryan White Part B Consortia and Emerging Communities, continued		
Report Name	Due Date*	Responsible Party
Mid-Year Progress Report (April -September contract year)	October 14 of contract year	Provider
Program Data Report (January-December contract year)	February of contract year	Provider
Client Complaint, Grievance, and Appeal Procedures Log (April 1-March 31 contract year)	20 th of each month following the month being reported	Lead Agency and/or Provider

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

Patient Care Networks General Revenue Funding		
Report Name	Due Date*	Responsible Party
Monthly Expenditure and Reimbursement Report	20 th of each month following the month being reported	Contract Manager and Provider
First Time This Year (FTTY) Report	20 th of each month following the month being reported	Provider
Provider/Sub-contractor Report	November 1	Provider
Client Complaint, Grievance, and Appeal Procedures Log (July 1-June 30 contract year)	20 th of each month following the month being reported	Lead Agency and/or Provider

Housing Opportunities for Persons with AIDS (HOPWA) (Housing and Urban Development – HUD)		
Report Name	Due Date*	Responsible Party
Monthly Expenditure and Reimbursement Report	20 th of each month following the month being reported	Contract Manager and Project Sponsor
First Time This Year (FTTY) Report	20 th of each month following the month being reported	Project Sponsor
Client Complaint, Grievance, and Appeal Procedures Log	20 th of each month following the month being reported	Lead Agency and/or Provider

ADAP Premium Plus Insurance		
Report Name	Due Date*	Responsible Party
<i>Monthly Expenditure and Reimbursement Report</i>	20 th of each month following the month being reported	Contract Manager and Provider
<i>Quarterly Demographic Report</i>	20 th of each quarter	Provider
<i>Implementation Plan</i> (April 1-March 31 contract year)	TBA	Contract Manager and Provider
<i>Revised Implementation Plan</i> (April 1-March 31 contract year)	May 30 of contract year <i>(Word Document)</i>	Provider
<i>Annual Progress Report</i> (April 1-March 31 contract year)	July 15 of contract year <i>(Word Document)</i>	Provider
<i>WICY Report</i> (April 1-March 31 contract year)	July 15 of contract year <i>(Word Document)</i>	Provider
<i>Mid-Year Progress Report</i> (April-September contract year)	October 14 after contract year <i>(Word Document)</i>	Provider
<i>Program Data Report</i> (January-December calendar year)	February after contract year	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 Unit 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 Part B programs. As with the 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 Florida State Housing Opportunities for Persons With AIDS (HOPWA) Program is funded by the U.S. Department of Housing and Urban Development, and it provides temporary mortgage, rent and utility assistance to eligible individuals with HIV/AIDS who meet program qualifications. There are 12 HOPWA service areas statewide that are administered by the Florida Department of Health.

ADAP

The AIDS Drug Assistance Program (ADAP) is a federally and state funded program that provides lifesaving medications, disease management and training to uninsured or underinsured persons living with HIV/AIDS in the state of Florida who have income at or below 400% of the Federal Poverty Level.

ADAP Premium Plus Insurance

The ADAP Premium Plus Insurance Program is a component of the ADAP program created to assist eligible ADAP clients who have prescription insurance coverage such as Medicare Part D, employer sponsored private insurance, or limited plans with out-of-pocket costs.

AIDS Insurance Continuation Program (AICP)

The AIDS Insurance Continuation Program, a component of ADAP Premium Plus, preserves the private health insurance coverage of low-income Floridians who cannot afford to pay their private health insurance premiums, deductibles and co-payments. The AICP ensures continuity of medical care to insured low-income Floridians living with HIV/AIDS at a significant cost savings to the state of Florida.

Appendix B: Glossary of Terms and Acronyms

ADA—Americans with Disabilities Act

ADAP—AIDS Drug Assistance Program

ADAP Premium Plus Insurance—AIDS Drug Assistance Program Premium Plus Insurance Program is a component of the ADAP program created to assist eligible ADAP clients who have prescription insurance coverage such as Medicare Part D, employer sponsored private insurance, or limited plans with out-of-pocket costs.

AICP—The AIDS Insurance Continuation 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 the Health Resources and Services Administration (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

The 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—The Health Resources and Services Administration is 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—The 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—The 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—The 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.

As of the most recent revision of the 2014-15 Administrative Guidelines (revised April 6, 2014), the HIV/AIDS and Hepatitis Section, Patient Care Program remains informed concerning the President's

proposed fiscal year 2015 budget consolidation of Part D funding within the Part C program. Any official changes to the description of Part D, made at the federal level, will be adapted and incorporated into this appendix.

PCN—General Revenue Patient Care Network

PCPG—Patient Care Planning Group

RSR—Ryan White HIV/AIDS Program Services Report

Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009)—

This legislation was first enacted in 1990 as the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. It has been amended and reauthorized four times: in 1996, 2000, 2006, and 2009. The Ryan White legislation has been adjusted with each reauthorization to accommodate new and emerging needs, such as an increased emphasis on funding of core medical services and changes in funding formulas.

The Ryan White HIV/AIDS Program is the largest Federal program focused exclusively on HIV/AIDS care. The program is for individuals living with HIV/AIDS who have no health insurance (public or private), have insufficient health care coverage, or lack financial resources to get the care they need for their HIV disease. As such, the Ryan White HIV/AIDS Program fills gaps in care not covered by other funding sources.

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

Appendix D: Requirements Regarding Imposition of Charges for Services

***ATTACHMENT:** Ryan White Treatment Extension Act Law Requirements (the following was abstracted from *Title 42-The Public Health and Welfare, Chapter 6A-Public Health Service, Subchapter XXIX-HIV Health Care Services Program, Part C-Early Intervention Services subpart ii-general provisions*; the provisions of P.L. 111-87 signed September 30, 2009 repealed P.L. 109-415 signed December 19, 2006):

<http://uscode.house.gov/view.xhtml?hl=false&edition=prelim&req=granuleid%3AUSC-prelim-title42-section300ff-64&f=treesort&fq=true&num=0&saved=%7CaW1wb3NpdGlvbiBvZiBjaGFyZ2Vz%7CdHJIZXNvcnQ%3D%7CdHJ1ZQ%3D%3D%7C164%7Ctrue%7Cprelim>.

(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 percent of the official poverty line, the applicant will not impose a charge on any such individual for the provision of early intervention services under the grant;

(B) in the case of individuals with an income greater than 100 percent of the official poverty line, the applicant-

(i) will impose a charge on each such individual for the provision of such services; and

(ii) will impose the charge 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 percent of the official poverty line and not exceeding 200 percent of such poverty line, the applicant 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 percent of the official poverty line and not exceeding 300 percent of such poverty line, the applicant will not, for any calendar year, impose charges in an amount exceeding 7 percent of the annual gross income of the individual involved; and

(C) in the case of individuals with an income greater than 300 percent of the official poverty line, the applicant will not, for any calendar year, impose charges in an amount exceeding 10 percent of the annual gross income of the individual involved.

(3) Assessment of charge

With respect to compliance with the agreement 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 and of paragraph (2) regarding limitations 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 this part unless the applicant for the grant agrees that the limitations established in paragraph (2) 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, copayments, coinsurance, or similar charges.

(5) Waiver regarding certain secondary agreements

The requirement established in paragraph (1)(B)(i) shall be waived by the Secretary in the case of any entity for whom the Secretary has granted a waiver under section 300ff–52(b)(2) of this title.

(f) Relationship to items and services under other programs**(1) In general**

The Secretary may not make a grant under this part unless the applicant for the grant agrees that, subject to paragraph (2), the grant will not be expended by the applicant, or by any entity receiving amounts from the applicant for the provision of early intervention services, to make payment for any such service to the extent that payment has been made, or can reasonably be expected to be made, with respect to such service-

(A) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program (except for a program administered by or providing the services of the Indian Health Service); or

(B) by an entity that provides health services on a prepaid basis.

(2) Applicability to certain secondary agreements for provision of services

An agreement made under paragraph (1) shall not apply in the case of an entity through which a grantee under this part provides early intervention services if the Secretary has provided a waiver under section 300ff–52(b)(2) of this title regarding the entity.

(g) Administration of grant

The Secretary may not make a grant under this part unless the applicant for the grant agrees that-

(1) the applicant will not expend amounts received pursuant to this part for any purpose other than the purposes described in the subpart under which the grant involved is made;

(2) the applicant will establish such procedures for fiscal control and fund accounting as may be necessary to ensure proper disbursement and accounting with respect to the grant;

(3) the applicant will not expend more than 10 percent of the grant for administrative expenses with respect to the grant, including planning and evaluation, except that the costs of a clinical quality management program under paragraph (5) may not be considered administrative expenses for purposes of such limitation;

(4) the applicant will submit evidence that the proposed program is consistent with the statewide coordinated statement of need and agree to participate in the ongoing revision of such statement of need; and

(5) the applicant will provide for the establishment of a clinical quality management program-

(A) to assess the extent to which medical services funded under this subchapter that are provided to patients are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infections, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines; and

(B) to ensure that improvements in the access to and quality of HIV health services are addressed.

(July 1, 1944, ch. 373, title XXVI, §2664, as added Pub. L. 101–381, title III, §301(a), Aug. 18, 1990, 104 Stat. 611; amended Pub. L. 104–146, §3(d)(5), May 20, 1996, 110 Stat. 1358; Pub. L. 106–345, title III, §§301(b)(3), 322, Oct. 20, 2000, 114 Stat. 1345, 1346; Pub. L. 109–415, title III, §§301(b), 306(b), (c), title VII, §§702(3), 703, Dec. 19, 2006, 120 Stat. 2806, 2809, 2820; Pub. L. 111–87, §2(a)(1), (3)(A), Oct. 30, 2009, 123 Stat. 2885.)

Amendments

2009-Pub. L. 111–87 repealed Pub. L. 109–415, §703, and revived the provisions of this section as in effect on Sept. 30, 2009. See 2006 Amendment note and Effective Date of 2009 Amendment; Revival of Section note below.

2006-Pub. L. 109–415, §703, which directed repeal of this section effective Oct. 1, 2009, was itself repealed by Pub. L. 111–87, §2(a)(1), effective Sept. 30, 2009.

Subsec. (a)(1)(C), (D). Pub. L. 109–415, §306(b)(1), added subpars. (C) and (D).

Subsec. (a)(3), (4). Pub. L. 109–415, §306(b)(2), (3), added pars. (3) and (4).

Subsec. (b)(1). Pub. L. 109–415, §702(3), substituted “HIV/AIDS” for “HIV disease”.

Subsec. (f)(1)(A). Pub. L. 109–415, §306(c), inserted “(except for a program administered by or providing the services of the Indian Health Service)” before semicolon.

Subsec. (g)(3). Pub. L. 109–415, §301(b)(1), amended par. (3) generally. Prior to amendment, par. (3) read as follows: “the applicant will not expend more than 10 percent including planning and evaluation of the grant for administrative expenses with respect to the grant;”.

Subsec. (g)(5). Pub. L. 109–415, §301(b)(2), inserted “clinical” before “quality management” in introductory provisions.

Subsec. (g)(5)(A). Pub. L. 109–415, §702(3), substituted “HIV/AIDS” for “HIV disease”.

2000-Subsecs. (e)(5), (f)(2). Pub. L. 106–345, §301(b)(3)(A), (B), struck out “300ff–42(b) or” after “a waiver under section”.

Subsec. (g)(3). Pub. L. 106–345, §322(1)(A), substituted “10 percent” for “7.5 percent”.

Subsec. (g)(5). Pub. L. 106–345, §322(1)(B), (2), (3), added par. (5).

Subsec. (h). Pub. L. 106–345, §301(b)(3)(C), struck out heading and text of subsec. (h). Text read as follows: “A State may not use amounts received under a grant awarded under section 300ff–41 of this title to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.”

1996-Subsec. (g)(3). Pub. L. 104–146, §3(d)(5)(B)(i), substituted “7.5 percent including planning and evaluation” for “5 percent”.

Subsec. (g)(4). Pub. L. 104–146, §3(d)(5)(A), (B)(ii), (C), added par. (4).

Effective Date of 2009 Amendment; Revival of Section

For provisions that repeal by section 2(a)(1) of Pub. L. 111–87 of section 703 of Pub. L. 109–415 be effective Sept. 30, 2009, and that the provisions of this section as in effect on Sept. 30, 2009, be revived, see section 2(a)(2), (3)(A) of Pub. L. 111–87, set out as a note under section 300ff–11 of this title.

Effective Date of 1996 Amendment

Amendment by Pub. L. 104–146 effective Oct. 1, 1996, see section 13 of Pub. L. 104–146, set out as a note under section 300ff–11 of this title.

Appendix E: Ryan White Program Definitions of 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 single 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 dietitian.

Nutritional services not provided by a licensed, registered dietitian 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 dietitian 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.
- z. Referral for health care/supportive services** is 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).
- aa. 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.
- ab. 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.
- ac. 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).
- ad. 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 F: Units of Service—Definitions

SERVICE CATEGORY	UNITS OF SERVICE
Ambulatory/Outpatient Medical Care	1 visit
AIDS Pharmaceutical Assistance (Local)	1 prescription for up to 30 days of medications ¹
Oral Health Care	1 visit
Health Insurance Premium/Cost Sharing	1 premium, deductible or co-payment ²
Home Health Care	1 visit ³
Mental Health Services - Outpatient	1 client encounter
Medical Nutrition Therapy	1 visit or 1 case of supplement ⁴
Medical Case Management (including Treatment Adherence)	1 Medical Case Manager encounter per client per day ⁵
Substance Abuse Services - Outpatient	1 client encounter
Case Management (non-medical)	1 Non-medical Case Manager encounter per client per day ⁵
Emergency Financial Assistance	1 assistance voucher or payment (rent or utilities)
Food Bank/Home Delivered Meals	1 bag/box of food or grocery store gift card/voucher ⁶
Linguistic Services	1 client encounter
Medical Transportation Services	1 one round trip transport or medical transportation voucher for bus, taxi or van, or 1 gas card ⁷
Psychosocial Support Services	1 individual or group encounter
Referral for Health Care/Supportive Services	1 client encounter
Substance Abuse Services – Residential	1 day

¹ 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.

² The unit of service is one premium, deductible or co-payment, regardless of the dollar amount of the payment.

³ 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 medical therapy, leaves then comes back to the client's home that same day, this is counted as one unit of service. If a different medical professional visits the same client on the same day as the nurse, this is counted as two units of service.

⁴ 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. If a nutritional supplement is provided during the visit to the licensed registered dietician, or on the same day as that visit, this counts as two units of service.

⁵ The unit of service is the sum of unduplicated clients seen or contacted for this service per day.

Example: A case manager meets with a client, discusses issues related to the client's care, and provides 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 of those activities on the part of the case manager are counted as one unit of service for that client. For the purpose of invoicing the Department, the unit of service for case management will be defined as one (1) eight (8) hour day of case management service provided.

⁶ Depending on how the program operates, a unit of service will be one bag/box of food, or one gift card/voucher for the purchase of groceries.

⁷ The unit of service is one round-trip transport or voucher for travel by bus, taxi, or van 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. If more than one means of transportation or a combination of transportation methods is used to fulfill a client's round-trip travel on a given day, this still constitutes one unit of service.

CAREWARE DATA ENTRY REQUIREMENTS

Purpose

The purpose 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 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.

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.

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.

Appendix I: 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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Vacant	Staff Assistant	2516	
HOPWA			
Name	Title/Function	Ext.	Email Address
Craig Reynolds	State HOPWA Program Coordinator	2539	Craig.Reynolds@flhealth.gov
Cheryl Urbas	State Housing Coordinator	2530	Cheryl.Urbas@flhealth.gov
Community Programs			
Name	Title/Function	Ext.	Email Address
Laura Rumph	Community Programs Supervisor	2541	Laura.Rumph@flhealth.gov
Uneeda Brewer	Community Programs Coordinator	2594	Uneeda.Brewer@flhealth.gov
James Easton	Community Programs Coordinator	2540	James.Easton@flhealth.gov
Meghan Daily	Community Programs Coordinator	2522	Meghan.Daily@flhealth.gov
Erin Penmann	Community Programs Coordinator	2560	Erin.Penmann@flhealth.gov
AIDS Drug Assistance Program (ADAP)			
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APPENDIX I

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Vacant	Actuary	N/A	
Reporting Unit			
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Jeffrey Storm	Business Analyst	2548	Jeffrey.Storm@flhealth.gov
Marrissa Walker	Technical Assistance	2554	Marrissa.Walker@flhealth.gov