



# **Patient Care Program Administrative Guidelines**

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

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**2016–2017**

# Patient Care Program Administrative Guidelines 2016-2017

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## Section 1: Introduction

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

- AIDS Drug Assistance Program (ADAP)
- General Revenue (GR)/4B000
- GR Patient Care Network (PCN)
- Housing Opportunities for Persons With AIDS (HOPWA)
- Ryan White (RW) Part B Consortia
- RW Part B Emerging Communities

A brief explanation of each of these programs is found in Appendix A. A glossary of acronyms and terms used in this guidance is included as Appendix B.

### A. Effective Date and HRSA Policy Changes

The requirements set forth in this document are effective upon release for RW Part B Consortia funds; and July 1, 2016, for PCN and GR funds. Any of the revisions and clarifications provided in the Health Resources and Services Administration (HRSA) Policy Clarification Notice #16-02 and subsequent Frequently Asked Questions document are implemented at the grantee's (the Department's) discretion. Therefore, please reference Patient Care Policy Notice #16-01 as amended for allowable costs of administrative and direct care line items related to this policy.

### B. 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 preparing 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 funding. These guidelines and any referenced manuals are updated to provide the most accurate, comprehensive information available. It is the contract manager's and lead agency's responsibility to ensure compliance with all updated guidelines and referenced manuals.

### C. Roles and Responsibilities: HIV/AIDS Section, Florida Department of Health

The Department is the grantee for Florida's federally funded Part B program. The HIV/AIDS 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 has HIV/AIDS Program Coordinators (HAPCs) and contract managers throughout the state to coordinate, provide oversight, and facilitate activities in their assigned areas, including accessing CAREWare, HMS, and other local data collection

systems as needed to investigate client issues. The Department enters into agreements with lead fiscal agencies to provide services to the HIV/AIDS population in compliance with program requirements.

The roles and responsibilities of the Department as grantee include, but are not limited to:

- Acts as fiscal administrator of all HIV/AIDS patient care funds.
- Coordinates statewide policy and procedures.
- Ensures compliance with all HIV/AIDS patient care requirements, which includes all guidelines and referenced manuals.
- Ensures match and Maintenance of Effort (MOE) of state funds.
- Ensures Part B and PCN are payers of last resort.
- Ensures the health and well-being of Floridians by providing access to HIV patient care and support services.
- Ensures the Part B care consortia conduct needs assessments, prepare service plans, and coordinate service provisions.
- Facilitates statewide meetings.
- Monitors and audits HIV/AIDS patient care activities.
- Prepares and reviews the Part B and PCN contracts.
- Prepares and submits the statewide Part B grant application to HRSA.
- Provides technical assistance.
- Responds to all federal and state programmatic and reporting requirements.

#### **D. Roles and Responsibilities: Contracted Lead Fiscal Agencies**

The Part B and PCN contracted lead fiscal agencies play an essential role in providing patient care and support services to the HIV/AIDS population. The Department enters into contractual agreements with lead agency organizations that may subcontract with other service providers.

The roles and responsibilities of contracted lead fiscal agencies include, but are not limited to:

- Act as data coordinator for the contracted providers within their area.
- Act as fiscal administrator of Part B and PCN funds.
- Adhere to reporting requirements as defined by the state and federal governments, and any subsequent changes to these requirements enacted during the program year.
- Administer needs assessments as required.
- Develop and ensure emergency procedures in preparation for disasters.
- Develop and execute subcontracts, purchase orders, and other provider agreements.
- Develop with the care consortia a local Integrated HIV Prevention and Care Plan.
- Develop with the care consortia service delivery guidelines with service caps.
- Ensure client satisfaction surveys are conducted and reviewed.
- Ensure subcontractors are entering data into CAREWare as required.
- Ensure subcontracts are in compliance with the primary contract. Contact managers should always check the Contract Administration's Intranet to ensure that the correct forms are being used. The following forms are completed as part of the subcontracting process:
  - Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Contracts/Subcontracts.

- Certification Regarding Lobbying (if required).
- Civil Rights Compliance Checklist.
- Conflict of Interest Questionnaire.
- Federal Recipient/Subrecipient and Vendor Determination Checklist (if required).
- Financial and Compliance Audit.
- Ensure training and technical assistance resource materials are available to consortia members (Part B only).
- Facilitate the provider selection process. 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 250-9-14.
- Maintain consortia files (Part B only).
- Monitor subcontractors.
- Organize consortia mailings (Part B only).
- Process invoices from subcontractors.
- Provide administrative support to the consortia and promote consumer involvement (Part B only).
- Provide technical assistance to subcontractors.
- Reimburse subcontractors.
- Sign the primary Part B and PCN contracts with the Department.
- Submit program and financial reports to the HIV/AIDS Section.
- Support the local planning body in the development of the Integrated HIV Prevention and Care Plan (Part B only).

## **E. Roles and Responsibilities: County Health Department Lead Fiscal Agencies**

In some areas of the state, the county health department (CHD) serves as the lead fiscal agency. For these CHD lead fiscal agencies, the Department puts the funding on the Schedule C. The CHDs prepare and submit HIV/AIDS patient care budgets using the required forms 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.

The roles and responsibilities of CHD lead fiscal agencies include, but are not limited to:

- Act as data coordinator for the contracted providers within their area.
- Act as fiscal administrator of Part B and PCN funds.
- Adhere to reporting requirements as defined by the state and federal governments, and any subsequent changes to these requirements enacted during the program year.
- Administer needs assessments as required.
- Develop and ensure emergency procedures in preparation for disasters.
- Develop and execute subcontracts, purchase orders, and other provider agreements.
- Develop with the care consortia a local Integrated HIV Prevention and Care Plan.
- Develop with the care consortia service delivery guidelines with service caps.
- Ensure client satisfaction surveys are conducted and reviewed.

- Ensure subcontractors are entering data into CAREWare as required.
- Ensure subcontracts are in compliance with the primary contract. Contact managers should always check the Contract Administration's Intranet to ensure that the correct forms are being used. The following forms are completed as part of the subcontracting process:
  - Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Contracts/Subcontracts.
  - Certification Regarding Lobbying (if required).
  - Civil Rights Compliance Checklist.
  - Conflict of Interest Questionnaire.
  - DH1122 Form.
  - Federal Recipient/Subrecipient and Vendor Determination Checklist (if required).
  - Financial and Compliance Audit.
- Ensure training and technical assistance resource materials are available to consortia members (Part B only).
- Facilitate the provider selection process. 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 250-9-14.
- Maintain and submit (upon request) back-up documentation for all expenditures charged to either Part B or PCN as reported in the Financial Information System (FIS) and AIDS Information Management System (AIMS) 2.0.
- Maintain consortia files (Part B only).
- Monitor subcontractors and outlying counties.
- Organize consortia mailings (Part B only).
- Process invoices from subcontractors.
- Provide administrative support to the consortia and promote consumer involvement (Part B only).
- Provide technical assistance to subcontractors.
- Reimburse subcontractors.
- Submit program and financial reports to the HIV/AIDS Section.
- Support the local planning body in the development of a local Integrated HIV Prevention and Care Plan (Part B only).

## **F. Lead Agency Policies**

Lead agencies and providers receiving Part B or PCN funding should have written and implemented fiscal, programmatic, and general policies and procedures that address the following:

- Bylaws and board policies regarding: (If Applicable)
  - Charges for copying documents.
  - Public access to records that are exempt.
  - Time-frames for providing documentation or procedures for denying access to documentation.
  - Types of records that must be produced or are to be made.
- Eligibility and clinical policies to ensure that providers do not:
  - Permit denial of HIV services due to non-HIV-related conditions (primary care).

- Permit denial of services due to pre-existing conditions.
- Provide any other barrier to care due to a person's past or present health condition.
- Financial policies and procedures that include:
  - Acknowledging the revisionary interest of the federal government over property improved or purchased with federal dollars.
  - Allowing 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.
  - Billing and collection, purchasing, procurement, accounts payable, and accounting.
  - Determining allowable and reasonable costs.
  - Guiding selection of an auditor.
  - Handling Part B or PCN revenues, including program income.
- Personnel policies incorporating:
  - 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.
  - Conflict of interest policy, including conflicts of interest in the procurement and contract management process as well as the planning processes of the consortium.
  - Information on regulations regarding lobbying with federal funds, which should be included in the personnel manual and employee orientation.
  - Policies and staff training on the requirement that Part B and PCN are the payers of last resort, and how that requirement is met.
  - Policies that discourage the use of two charge masters--one for self-pay clients and a higher one for insurance companies.
  - Policies that prevent the hiring of persons with a felony criminal record; the hiring of persons being investigated by Medicare or Medicaid; and signing bonuses.
  - Purchasing policies that discourage kickbacks and referral bonuses per HRSA universal monitoring standards.
- Other policies and procedures regarding:
  - Client Complaint, Grievance, and Appeal Procedures (Appendix G) for details.
  - Code of ethics or standards of conduct.
  - Establishing 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.
  - Forbidding the use of Part B and PCN funds for cash payments to service recipients.
  - Providing transportation if the facility is not accessible to public transportation (either by referral or vouchers).

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

Consortia act in an advisory capacity to the HIV/AIDS Section for the purpose of planning and prioritizing the use of Part B funds. The consortia must include People Living with HIV/AIDS (PLWH); provide a forum for community stakeholders, providers, and others; and facilitate the provision of coordinated, comprehensive health and support services to PLWH.

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

- Capacity development
- Comprehensive planning

- Coordination
- Priority setting
- Service delivery

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

- Development and recruitment of members to ensure an effective planning body.
- Development of service priority funding recommendations.
- Evaluation of the effectiveness of the consortia.
- Participation in the development of the Integrated HIV Prevention and Care Plan.
- Promotion of the coordination and integration of community resources.

## H. Payer of Last Resort

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

## I. Program References

Listed below are Internet links to resource materials:

- Chapter 64D-4, *Florida Administrative Code (F.A.C.)*:  
<https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64D-4>
- Chapter 64F-16.006, *Florida Administrative Code (F.A.C.)*:  
<https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64F-16>
- *Checklist for the Review of an HIV-Specific Quality Management Plan*:  
<http://nationalqualitycenter.org/files/agm-2006-resources-2/09-quality-managment-plan-review-checklist-5-16-06/>
- Florida Department of Health, HIV/AIDS Section:  
<http://www.floridahealth.gov/diseases-and-conditions/aids/index.html>
- Florida Department of Health, HIV/AIDS Section, Patient Care Policy Notices:  
<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/patient-care-program-notices.html>
- Florida Department of Health, HIV/AIDS Section, Patient Care Program, *CAREWare User Manual*:

<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/reporting/index.html>

- *Florida HIV/AIDS Case Management Operating Guidelines:*  
<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/community-programs.html>
- *Florida HIV/AIDS Ryan White Part B Eligibility Procedures Manual:*  
<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/eligibility-information1.html>
- HRSA HIV/AIDS Bureau:  
<http://hab.hrsa.gov/>
- HRSA Monitoring Standards:  
<http://hab.hrsa.gov/manageyourgrant/granteebasics.html>
- HRSA Program Policy Notices and Program Letters:  
<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>
- *Integrated HIV Prevention and Care Plan Guidance, Including the Statewide Coordinated Statement of Need, CY 2017-2021:*  
<http://hab.hrsa.gov/manageyourgrant/hivpreventionplan062015.pdf>
- *National HIV/AIDS Strategy for the United States, Updated to 2020:*  
<https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf>
- Ryan White HIV/AIDS Program (Parts A-D):  
<http://hab.hrsa.gov/abouthab/aboutprogram.html>
- *Ryan White HIV/AIDS Program Part B Manual:*  
<http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf>
- *Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual:*  
<https://careacttarget.org/library/ryan-white-hivaids-program-services-report-rsr-instruction-manual>
- *Using Data to Measure Public Health Performance: A Guide for Ryan White HIV/AIDS Program Grantees:*  
<http://hab.hrsa.gov/manageyourgrant/files/datatomeasure2010.pdf>

## 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 Section must be determined eligible based on Chapter 64D-4, *F.A.C.* All providers that determine core eligibility are required to enter eligibility information on every client into the state CAREWare system as outlined in the *Florida HIV/AIDS Ryan White Part B Eligibility Procedures Manual* and *CAREWare User Manual*. It is the responsibility of the agency that determines a client's eligibility to ensure that this process is done correctly.

### B. Subcontractors

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

- All subcontracts must contain language and restrictions similar to the primary contract including scope of work, which contains key activities/services to be rendered and documentation required to substantiate the delivery of service.
- All subcontracts should model the Part B or PCN lead agency contract.
- 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 250-9-14.
- 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 and required budget forms in the contracts folder on the Department's shared drive within 30 days of receipt.
- Lead fiscal agencies must ensure that subcontracts are in compliance with the primary contract. Contact managers should always check the Contract Administration's Intranet to ensure that the correct forms are being used. The following forms are completed as part of the subcontracting process:
  - Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Contracts/Subcontracts.
  - Certification Regarding Lobbying (if required).
  - Civil Rights Compliance Checklist.
  - Conflict of Interest Questionnaire.
  - Federal Recipient/Subrecipient and Vendor Determination Checklist (if required).
  - Financial and Compliance Audit.
  - Scrutinized Company Certification (if applicable).
- No subcontracts are to be executed prior to execution of the primary contract between the provider and the Department.
- Part B and PCN lead agencies are required to submit subcontractor information when setting up their contracts in AIMS 2.0.
- 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.

## C. Medical and Non-Medical Case Management

The *Florida HIV/AIDS Case Management Operating Guidelines* provide the operating guidelines for case management service providers funded by the Department's HIV/AIDS 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. Case managers will be required to complete training through the Southeast AIDS Training and Education Center once they are available. At the release of this document, the website is under construction and supervisors should not penalize staff who have not taken medical case management training. The HIV/AIDS Section will release a Patient Care Policy Notice when the trainings become available.

Case management represents a large portion of the Patient Care Program allocations each year. Improved fiscal and program accountability continues to be emphasized to ensure sustained funding and service delivery. Medical and non-medical case management positions are required to have a caseload, must enter client data into CAREWare, and adhere to the requirements of a case manager as defined in the *Florida HIV/AIDS Case Management Operating Guidelines*. Non-medical case management 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.

Every full-time equivalent (FTE) case manager must maintain a continuous minimum caseload of 60 clients throughout the contract year. 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 not considered to be an administrative cost, and staff who do not provide any case management services but conduct core eligibility assessments may be funded under the "case management services (non-medical)" line item.

The caseload of a case management supervisor is the combined caseload of all supervised staff. For a case management supervisor to be funded under either the "medical case management services (including treatment adherence)" or "case management services (non-medical)" line item, they must perform (at a minimum) the following tasks:

- Conduct interdisciplinary team meetings and/or facilitate meetings with partnered providers regarding client-specific issues.
- Conduct monthly chart reviews for quality management.
- Fill in for staff out of the office due to sick leave, annual/vacation leave, etc.
- Hire and terminate staff.
- Train new staff.

## **D. Required Data Elements**

Lead agencies must ensure that patient care services paid for by Part B, PCN, or GR are entered into the CAREWare system for reporting purposes in accordance with the *CAREWare User Manual*. The HIV/AIDS Section will monitor the use of CAREWare for accuracy and completeness of data collection as described in the *Florida HIV/AIDS Ryan White Part B Eligibility Procedures Manual*, *Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual*, and *Using Data to Measure Public Health Performance: A Guide for Ryan White HIV/AIDS Program Grantees*.

## **E. 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, or 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 payment of services rendered.

## **F. 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 is the local rate for home-delivered meals.

Each lead agency must create in collaboration with the local consortium a service delivery guideline that includes caps for services. This service delivery guideline must be made available to current and new Part B or PCN clients upon request for clarification of services.

## **G. Vital Status**

When closing a client in CAREWare due to death: (1) update the Enrollment Status to Referred/Discharged; (2) change the Vital Status to Deceased; (3) enter a Date of Death and (4) enter a Case Closed Date. The close date should match the date of death unless the client was closed out prior to death. Do not post the entry as a service for referral for healthcare/supportive service, medical case management, or non-medical case management. Providers cannot bill for services after a client is deceased or when closing a client file due to death. Finally, add any necessary notes in the case notes section and/or comments box.

## Section 3: Contract Budget

The Department's contract manager must save on the shared drive all lead agency budget documents, including the budget summary, budget narrative, and any subsequent revisions. These documents are to be saved in the "Budget Documents" folder within the current contract year for Part B and GR funding. The naming convention shall contain the document name and effective date; for example, "Budget Summary 4-1-16" and "Budget Narrative 4-1-16." After the documents are posted to the shared drive, the contract manager must email the designated Community Programs Coordinator and the appropriate Reporting Unit staff.

**Example: AIDS\CONTRACTS\AREA01\RYAN WHITE\Ryan White 16-17\Budget Documents\Budget Summary 4-1-16**

### A. Budget

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

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

- To coordinate and expand existing services, and to identify service gaps and barriers to care.
- To provide comprehensive outpatient, essential health and support services for individuals infected with HIV.
- To provide health and support services to women and youth with HIV, including treatment measures to prevent the perinatal transmission of HIV.
- To provide services that prevent unnecessary hospitalization.

### B. Budget Categories

Budget categories contained in the budget summary and budget narrative of the contract are explained in this section. There are four potential sections for the provider to consider when developing a budget.

The following documentation will be required in order for the provider to be paid for funded positions. Sufficient documentation would include the following:

- Invoices for fringe benefits (health care, dental, life, disability, retirement, etc.). Invoices should show the provider's name, address, period of benefit coverage, amount of total invoice, and amount paid for each applicable employee.
- Payroll journal from the payroll company. Funded staff 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 for the corresponding fringe benefit.
- Proof of payment to the payroll company.

## 1. Administrative Costs

- a. Provisions: Lead agencies must ensure that administrative expenditures (inclusive of all subcontracts) do not exceed 7.5% of the aggregate total funds awarded to the area annually. Subcontracted administrative expenses may be individually set and may vary by area at the discretion of the lead agency; however, the aggregate total of the area's administrative costs may not exceed the 7.5% limit. All indirect costs charged are considered an administrative cost subject to the 7.5% aggregate limit. For example, lead agency XYZ is awarded \$10,000. Of that amount, \$750 (7.5%) may be used towards administrative expenses. In this example lead agency XYZ may elect to keep the entire \$750, or they may retain a portion (\$500) and allocate the remaining portion (\$250) among some or all subcontracts. However the administrative funds are allocated, the area's aggregate total administrative expenses must not exceed the 7.5% (\$750).

All indirect expenses must be considered administrative expenses subject to the cap. Administrative activities include:

- All activities associated with contract award procedures, including the development of requests for proposals, subrecipient and contract proposal review activities, negotiation, and awarding of contracts.
- Communication expenses, such as postage.
- Compliance with grant conditions and audit requirements.
- Development and establishment of reimbursement and accounting systems.
- Facility security expenses.
- Insurance for vans used for mobile clinics, transportation services, or meal delivery.
- Malpractice insurance for attorneys and other legal staff.
- Malpractice or liability insurance for a clinic or facility.
- Management oversight.
- Monitoring activities, including telephone consultation, written documentation, and on-site visits.
- Office equipment, such as tablets and computers (tablets and computers related to case management activities may be purchased under the appropriate case management line item within the specified cap).
- Office supplies, such as copy paper, pens, paper clips, and rulers.
- Preparation of routine programmatic and financial reports.
- Program support, such as quality assurance, quality control, and related activities (exclusive of Clinical Quality Management).
- Related payroll, audit, and general legal services.
- Reporting on contracts, and funding re-allocation activities.
- Routine grant administration and monitoring activities, including the development of applications, and the receipt and disbursement of program funds.
- Usual and recognized overhead activities, including established indirect rates for agencies.

- 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 (and position number for CHDs).
  - (2) Job responsibilities as related to the funded work.
  - (3) Salary breakdown.
    - 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.
- c. **Fringe Benefits:** The following fringe benefits must be included in the budget narrative:
- (1) Federal Insurance Contributions Act (FICA)--include the 7.65 % 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 a position funded by Part B or PCN is vacant for more than two weeks, it 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 specify who, what, where, when, how, and why the travel is necessary.

General travel requires completion of the Department Authorization to Incur Travel Expenses (form C-676C) prior to travel, as well as the Department Voucher for Reimbursement of Travel Expenses (form 676A) submitted after completion of travel to the contract manager along with original receipts for expenses incurred during officially authorized travel, including items such as car rental, air transportation, parking, lodging, tolls, and fares. Refer to the "Required Travel Forms" (Appendix I) for images of these forms or request an electronic version from your contract manager.

Use of Part B and PCN funds 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 travel forms.

## 2. Direct Care Costs

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. According to HRSA, funding for support services must contribute to

positive medical outcomes. Providers must document in the budget narrative and in the individual case notes that support service funds are contributing to positive medical outcomes for clients.

The portion of facilities expenses (limited to rent and utilities; or interest, depreciation, and utilities) for space primarily utilized to provide core medical and support services to eligible Ryan White Part B clients (e.g., clinic, pharmacy, food bank, substance abuse treatment, case management, eligibility determination) are allowable direct care expenses (and NOT administrative costs). The allocation methodology or base for rent and utilities; or interest, depreciation, and utilities must be selected appropriately according to the Code of Federal Regulations (CFR) Title 45, Part 75 ("Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards," also known as the "Uniform Guidance") and its appendices referenced in the HRSA Policy Clarification Notice #15-01 and Frequently Asked Questions document dated May 15, 2015.

The following programmatic costs are not required to be included in the limit on administrative costs; they may be charged to the relevant service category directly associated with such activities. However, no more than 5% of the total amount allocated to each relevant direct care line item (core or support) may be charged as it relates to the following items:

- Core eligibility determination and re-certification as well as the costs of registration and client intake activities if the client is eligible for services.
- Portion of a clinic receptionist's time providing direct patient care services (e.g., scheduling appointments and other intake activities).
- Portion of a supervisor's time devoted to providing professional oversight and direction regarding patient care funded core medical or support service activities sufficient to assure the delivery of appropriate and high-quality HIV care to clinicians, case managers, and other individuals providing services to patient care clients (would not include general administrative supervision of these individuals).
- Portion of fees and services for electronic medical records maintenance and licensure.
- Portion of malpractice insurance related to patient care clinical care and for all licensed practitioners related to HIV/AIDS clinical care.
- Portion of medical billing staff related to patient care services.
- Purchase of tablets and computers for positions solely funded by medical and non-medical case management.
- Staff time for data entry related to clinical care and support services; and the costs of client level data entry in the relevant electronic health record directly related to the individual's ongoing care and treatment are allocable to the relevant core medical or support service. However, client level data used to improve the quality of service delivery and thus the health of the people living with HIV are allocable to CQM; and client level data entered to complete the Ryan White Services Report count toward the 7.5% administrative limit.

In the budget summary under the column labeled "Original Allocation," lead agencies are required to enter the amount for the appropriate funding 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.

In the budget narrative, lead agencies are required to provide the following components for each funded line item:

- Service category--name the service (e.g., case management non-medical).
- Rent/occupancy cost and justification (if applicable)--provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.
- Utilities cost and justification (if applicable)--provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.
- Other allowable programmatic administrative costs and justification (if applicable)--list the allowable programmatic expenses with associated costs that are not required to be included in the administrative costs as specified in PCPN #2016-01. **[NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.]** Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.
- Providers/facilities--list all providers or facilities where services will be provided.
- Additional provider/facility information--provide the authorization protocol (the process for approving and tracking an authorized service for a client), how the provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, and service limitations and caps.
- Allocation methodology--explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.
- Additional information--include any information that would be helpful in describing the service delivery system for this service. This may include a description of guiding principles developed by the consortium, and other related policies or guidelines.

Part B and PCN funds may not be used for the following:

- Billing for food that does not fall under the direct care budget line item of “food bank/home delivered meals.”
- Broad scope awareness activities about HIV services that target the general public.
- Clothing.
- Direct cash payments to service recipients.
- Drug use and sexual activity. Funds cannot be used to support AIDS programs or materials designed to promote or directly encourage intravenous drug use or sexual activity whether homosexual or heterosexual.
- Employment and employment readiness services.
- Funeral, burial, cremation, or related expenses.
- Household appliances.
- Lobbying activities.
- Local or state personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
- Maintenance of privately owned vehicles.

- Off-premise social/recreational activities or payments for a client's gym membership.
- Pet foods or other non-essential products.
- Pre-exposure prophylaxis.
- Purchase of vehicles.
- Purchase or improve land; or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility.
- Syringe services distributing sterile needles or syringes for hypodermic injection of any illegal drugs.

### 3. Clinical Quality Management (CQM) Costs

Lead agencies must ensure that CQM expenditures (inclusive of all subcontracts) do not exceed 5% of the aggregate total of funds awarded to the area annually. Subcontracted CQM expenses may be individually set and may vary by area at the discretion of the lead agency; however, the aggregate total of the area's CQM costs may not exceed the 5% limit.

CQM activities include:

- Capacity building--refers to training and development on human resources. It encompasses human, scientific, technological, organization, and institutional resource capabilities. It seeks to equip individuals with understanding, skills, and access to information, knowledge, and training that enables them to participate and contribute effectively to the delivery of HIV care.
- CQM--quality management encompasses continuous quality improvement activities and the management of systems that foster such activities as communication, education, and commitment of resources. The integration of quality throughout an organization or agency is referred to as "quality management." The quality management program embraces both quality assurance and quality improvement in an interdisciplinary, collaborative way.
- Data collection and management--collection and management of information, statistics, facts, figures, and/or numbers that inform decision making and the establishment of objectives. Data are also used to quantify performance levels.

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

- (1) Position title (and position number for CHDs).
- (2) Job responsibilities as related to the funded work.
- (3) Salary breakdown.
  - 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.

#### 4. Planning and Evaluation Costs

Lead agencies must ensure that planning and evaluation expenditures (inclusive of all subcontracts) do not exceed 2.5% of the aggregate total of funds awarded to the area annually. Subcontracted planning and evaluation expenses may be individually set and may vary by area at the discretion of the lead agency; however, the aggregate total of the area's planning and evaluation costs may not exceed the 2.5% limit.

The planning and evaluation service category should be used for activities related to planning for use of Ryan White HIV/AIDS patient care funds, and evaluating the effectiveness of those funds in delivering needed services. These activities include the following:

- Capacity building (to increase the availability of services)--capacity building activities aimed at increasing the availability of services to eligible HIV-positive clients through the agency's service network.
- Needs assessment--gather an array of information in order to identify trends and common themes among the HIV-positive population.
- Program evaluation--structured interpretation and giving of meaning to predicted or actual impacts of proposals or results. It looks at original objectives, what is either predicted or what was accomplished, and how it was accomplished (e.g., assessment of service delivery patterns).

Planning and evaluation 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.

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

- (1) Position title (and position number for CHDs).
- (2) Job responsibilities as related to the funded work.
- (3) Salary breakdown.
  - 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.

### C. Subcontract Budgets

All subcontracts must be prepared using the budget guidelines. During the contract review process, the allocations for administrative costs, direct care costs, CQM, and planning and evaluation will be compared with the prior year's allocation for significant increases, decreases, or eliminations.

### D. Budget Revisions

Budget revisions to patient care contracts do not require a contract amendment. However, the provider must report all budget revisions using the budget summary and complete the columns labeled "Increase/Decrease" and "Revised Allocation." In addition, the Part B budget narrative

detailing the administrative, direct care, CQM, and planning and evaluation line items must be updated to reflect the current budget revision. The Department's contract manager will approve or deny the revised budget summary and budget narrative. **[NOTE: The revised budget summary can only be executed when the document has been signed and dated by the Department's contract manager.]**

Revisions that will increase/decrease the administrative, direct care, CQM, and planning and evaluation categories may be requested from the lead agency and approved as described below. A contract manager may approve a budget revision that moves money from the administrative, CQM, and planning and evaluation categories into the direct services category without prior approval from the community programs coordinator. Likewise, a contract manager may approve a budget revision that moves money from a support service line item into a core service line item without prior approval from the community programs coordinator. However, if a lead agency submits a budget revision that moves money from the direct services category into one of the following categories: administrative, CQM, and planning and evaluation categories; then the contract manager needs to receive prior approval in writing from a community programs coordinator, the community programs supervisor, or the patient care program manager. The contract manager must also receive prior approval when a budget revision moves money from a core service line item into a support service line item.

Any budget revisions requested within the last 30 days of the contract must be approved in writing by the Division of Disease Control and Health Protection, Contracts 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, as indicated by the signed budget summary.

Once a revision is reviewed and approved, the contract manager will place the revised budget summary and budget narrative in the contract file and on the shared drive, and send a copy to the following by email:

- Community Programs Coordinator.
- Division of Disease Control and Health Protection, Contracts Unit.
- Reporting Unit.

## **E. 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" website under the "Policy" tab (<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/community-programs.html>). 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; this QFR should be submitted with the monitoring report. All other QFRs should be retained locally with back-up documentation and provided upon request.

## 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, 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 Section's Community Programs Coordinators will monitor CHDs serving as the lead agency.

The need for corrective action(s) 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's shared drive.

For contract managers, the universal and programmatic as well as the fiscal and contract monitoring templates can be found on the "Community Programs" website under the "Contracts" tab (<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/community-programs.html>). 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 "Exceeded Requirements."

All lead agency monitoring documents, including the completed monitoring tools, the monitoring report, the letter to the provider, and page one of the DH 1122 form, are to be placed in a "Completed Contract Monitoring" folder on the shared drive. After the documents are posted to the shared drive, the contract manager should via email notify the designated liaison in the Division of Disease Control and Health Protection, Contracts Unit, and the designated Community Programs Coordinator.

### B. Monitoring of Subcontracted Providers

Lead agencies are responsible for:

- Being familiar with HRSA's fiscal, program, and universal national monitoring standards as well as the most current *Ryan White HIV/AIDS Program Part B Manual*.
- Ensuring that subcontractors (especially new subcontractors or subcontractors that have received an increased contract payment amount of 25% 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 HAPC 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.

- Monitoring subcontracted providers for compliance with the subcontract, and providing the monitoring reports to the Department contract manager.
- Participating in area conference calls as needed.
- Providing a list of projected monitoring dates to the contract manager within 30 days of the start of the contract.
- Reviewing and monitoring the data providers are required to enter into CAREWare.
- Supporting subcontracted providers with technical assistance as needed.

Contract managers are responsible for:

- Being familiar with HRSA's fiscal, program, and universal national monitoring standards as well as the most current *Ryan White HIV/AIDS Program Part B Manual*.
- 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.
- Obtaining a list of projected monitoring dates from the lead agency within 30 days of the start of the contract.
- Participating in area conference calls as needed.
- Reviewing and monitoring the data lead agencies are required to enter into CAREWare as well as the reports required for submission to the Reporting Unit via AIMS 2.0 as listed in Section 5.
- Supporting lead agencies with technical assistance as needed.

### **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.

HRSA's fiscal, program, and universal national monitoring standards have been incorporated into the Patient Care Program's monitoring tools; these tools must be used for both Part B and PCN contracts, and subcontracts. It is the lead agency's and contract manager's responsibility to be familiar with these standards. Listed below are Internet links to HRSA's Part B national monitoring standards:

- HRSA Fiscal Monitoring Standards:  
<http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringpartb.pdf>
- HRSA Program Monitoring Standards:  
<http://hab.hrsa.gov/manageyourgrant/files/programmonitoringpartb.pdf>
- HRSA Universal Monitoring Standards:  
<http://hab.hrsa.gov/manageyourgrant/files/universalmonitoringpartab.pdf>
- HRSA FAQs:  
<http://hab.hrsa.gov/manageyourgrant/files/programmonitoringfaq.pdf>

In the context of the HRSA standards, "grantee" refers to the HIV/AIDS Section or its designee, including the Department contract manager. "Agreements" refer to contracts, subcontracts, memoranda of agreement or other similar written agreements, 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.

## **Section 5: Reporting Requirements**

### **A. Reporting Overview**

All HIV/AIDS Patient Care Program contracted providers and CHDs 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 are free to establish additional data collection systems to accurately meet state and federal reporting requirements; however, services funded by Part B, PCN, GR/4B000, and HOPWA must be entered and/or uploaded in the Department’s instance of CAREWare.

In order to assist contracted providers and CHDs in meeting their reporting requirements, the HIV/AIDS Section has developed AIMS (AIDS Information Management System) 2.0. AIMS 2.0 is a web-based, aggregate level reporting system that allows primary contracted providers and CHDs to electronically report to the HIV/AIDS Section. Questions or concerns about AIMS 2.0 reporting should be directed to a member of the Reporting Unit staff via the Florida Department of Health IT Help Desk at (850) 922-7599. AIMS 2.0 access and training can be arranged by contacting a member of the Reporting Unit staff.

Lead agencies are expected to report aggregate data on client demographics and expenditures in AIMS 2.0 and client level data directly or indirectly (i.e., manual data entry or data upload) into CAREWare. The Reporting Unit will be responsible for assisting CHDs in creating and setting up domains in CAREWare for data entry, if necessary.

The *Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual; Using Data to Measure Public Health Performance: A Guide for Ryan White HIV/AIDS Program Grantees*; and the *CAREWare User Manual* should be used as guidance for reporting requirements. Appendix F lists what constitutes a unit of service for each direct care service category.

## B. Report Submission

<b>Ryan White Part B Consortia and Emerging Communities</b>		
<b>Report Name</b>	<b>Due Date*</b>	<b>Responsible Party</b>
<b>Annual Progress Report</b> (April 1 - March 31 of previous contract year)	Finalized report due in June of the reporting year; includes Final Implementation Plan. <b>Report submitted via AIMS 2.0.</b>	Provider
<b>Final Expenditure and Reimbursement Report</b>	45 days from the end of the contract end date (e.g., if the contract ends March 31 <sup>st</sup> , the report is due by May 15 <sup>th</sup> ). <b>Report submitted via AIMS 2.0.</b>	Contract manager and provider
<b>First Time This Year (FTTY) Report</b>	Within 20 days from the end of each month or with the monthly invoice, whichever is earlier. <b>Report submitted via AIMS 2.0.</b>	Provider
<b>Monthly Expenditure and Reimbursement Report</b>	Within 20 days from the end of each month or with the monthly invoice, whichever is earlier. <b>Report submitted via AIMS 2.0.</b>	Contract manager and provider
<b>Program Terms Report</b> (April 1 - March 31 of current contract year)	Finalized report due in May of the reporting year; includes Revised Implementation Plan. <b>Report verified and submitted via AIMS 2.0.</b>	Provider
<b>Provider/Sub-Contractor Report</b> (April 1 - March 31 of current contract year)	Identification of sub-contractors is completed during budget planning in AIMS 2.0; report is generated from this data, and is due in May of the reporting year. <b>Data collected via AIMS 2.0.</b>	Provider
<b>Ryan White Services Report (RSR)</b> (January - December of contract year)	Finalized report due in the HRSA Electronic Handbook in March; providers must submit preliminary RSR reports in the HRSA	Provider

	Electronic Handbook by February 15 <sup>th</sup> of each reporting year.	
<b>Women, Infants, Children, and Youth (WICY) Report</b> (April 1 - March 31 of previous contract year)	Finalized report due in June of the reporting year. <b>NOTE: Provider is <u>not</u> required to submit a report; WICY data is collected via monthly FTTY report.</b>	Provider

General Revenue Patient Care Network		
Report Name	Due Date*	Responsible Party
<b>Final Expenditure and Reimbursement Report</b>	45 days from the end of the contract end date (e.g., if the contract ends June 30 <sup>th</sup> , the report is due by August 14 <sup>th</sup> ). <b>Report submitted via AIMS 2.0.</b>	Contract manager and provider
<b>First Time This Year (FTTY) Report</b>	Within 20 days from the end of each month or with the monthly invoice, whichever is earlier. <b>Report submitted via AIMS 2.0.</b>	Provider
<b>Monthly Expenditure and Reimbursement Report</b>	Within 20 days from the end of each month or with the monthly invoice, whichever is earlier. <b>Report submitted via AIMS 2.0.</b>	Contract manager and provider
<b>Provider/Sub-Contractor Report</b> (July 1 - June 30 of current contract year)	Identification of sub-contractors is completed during budget planning in AIMS 2.0; report is generated from this data, and is due in November of the reporting year. <b>Data collected via AIMS 2.0.</b>	Provider

\* 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 Section, Patient Care Administered Programs/Funding Streams**

## **AIDS Drug Assistance Program (ADAP)**

The ADAP is a federal 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 (FPL).

The ADAP Premium Plus Insurance Program is a component of the ADAP 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. 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. ADAP Premium Plus ensures continuity of medical care to insured low-income Floridians living with HIV/AIDS at a significant cost savings to the State of Florida.

## **General Revenue (GR)/4B000**

There are 33 CHDs that receive specific GR/4B000 funding to operate HIV/AIDS patient care programs to improve the health of HIV/AIDS patients.

## **GR Patient Care Networks (PCN)**

There are seven HIV/AIDS PCN programs in the State of Florida. These programs are funded by GR through the Florida Legislature to provide HIV/AIDS patient care programs with similar services as the Ryan White Part B programs. As with the Part B program, the Department contracts with fiscal lead agencies to provide these services in the PCN areas.

## **Housing Opportunities for Persons With AIDS (HOPWA)**

The Florida State HOPWA Program is funded by the U.S. Department of Housing and Urban Development (HUD). The Florida State HOPWA Program provides the following HOPWA services to eligible individuals with HIV/AIDS who meet program qualifications:

- Short-Term Rent, Mortgage, and Utility (STRMU) assistance.
- Tenant-Based Rental Assistance (TBRA).
- Permanent Housing Placement (PHP).
- Short-term supported housing facilities (transitional housing).
- Resource identification services.
- Housing case management.

- Other supportive services including, but not limited to, nutritional services, mental health, drug and alcohol treatment, and assistance in gaining access to local, state, and federal government benefits and services.

There are 11 HOPWA service areas statewide that are administered by the Department.

## **Ryan White Part B Consortia**

The Ryan White HIV/AIDS Treatment Extension Act of 2009 (hereinafter referred to as the 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 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 develop local comprehensive plans.

## **Ryan White Part B Emerging Communities**

HRSA defines an "emerging community" as an area reporting between 500 and 999 cumulative reported AIDS cases over the most recent five years. Ryan White Part B Emerging Communities are funded annually, provide services very similar to the Ryan White Part B consortia, and coordinate services and planning activities with their local consortium.

## Appendix B: Glossary of Acronyms and Terms

**ADAP**—AIDS Drug Assistance Program.

**ADAP Premium Plus Insurance**—Component of the ADAP 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**—Acquired Immune Deficiency 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 Section, which allows primary contracted providers and CHDs to electronically report to the HIV/AIDS Section.

**ARV**—Antiretroviral Therapy.

**CARE**—Comprehensive AIDS Resources Emergency.

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

**CFR**—Code of Federal Regulations.

**CHD**—County Health Department.

**CQM**—Clinical Quality Management.

**Department**—Florida Department of Health.

**DOHP**—Department of Health Policy (state).

**F.A.C.**—Florida Administrative Code.

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

**FIS**—Financial Information System.

**FPL**—Federal Poverty Level.

**FTE**—Full-Time Equivalent.

**HAB**—HIV/AIDS Bureau, HRSA (federal).

**HAPC**—HIV/AIDS Program Coordinator.

**HHS**–Health and Human Services (federal).

**HIV**–Human Immunodeficiency Virus.

**HMS**–Health Management System.

**HOPWA**–Housing Opportunities for Persons With AIDS.

**HRSA**–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.

**Part A**–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**–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**–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.

**PCN**–Patient Care Networks (General Revenue).

**PCPG**–Patient Care Planning Group.

**PLWH**–People Living with HIV/AIDS.

**QFR**–Quarterly Financial Report.

**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 (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.

**USC**–United States Code (federal).

**WICY**—Women, Infants, Children, and Youth.





e) Is cash that is received in the mail received, opened and listed by someone not involved in recording entries in the cash receipts journal?		
f) Are all employees, officers, servants and agents who are authorized to sign checks and handle funds properly bonded?		
g) Does a person other than the one who prepares the bank deposit actually make the deposit? There are no "cash" deposits, only checks?		
h) Is the payroll approved by an officer who is not responsible for its preparation and is outside the payroll department?		
9. Do financial management personnel have adequately trained staff?		
10. Are all accounting records stored in a fireproof lockable cabinet when not in use?		

**Comments:**

**REVENUE**

	YES <input checked="" type="checkbox"/>	NO <input checked="" type="checkbox"/>
1. Are receipts recorded in the Cash Receipt Journal by individual cost centers and/or funding source? (This includes third party payments, interest income, client fees, local funds and state and federal funds.)		
2. Does the provider have an equitable system of allocating fees and other third party payments to funding sources when two or more sources are involved?		
3. Are there controls to ensure that all appropriate costs for services provided are billed to third party payers and/or other responsible parties in a timely manner?		
4. Are there guidelines for assessing fees? Are these known to the bookkeeper/cashier?		
5. Are there procedures to notify the accounting or bookkeeping section when a client's classification or type of service is changed?		
6. Does the provider ensure that every effort was extended to collect fees?		
a) Is this documented?		
b) Are the efforts sufficient?		
7. Are uncollected write-offs approved by a responsible official?		
8. Are accounts receivable reconciled to the general ledger accounts monthly?		
9. Does the provider maintain an excessive cash balance created by cash advances from the Department?		



- 11. Are all individual positions paid within the budgeted amount specified in the approved contract?
- 12. Does the most recent Federal Quarterly Payroll Tax Form (U.S. 941) verify that the provider is remitting payroll taxes including federal withholding tax and both employee and employer share of FICA?
- 13. Are individual payroll records kept on each employee?
- 14. Are expenditures reasonable in the assessment of the reviewer? Are they allowable under the terms and conditions of the contract?


**Comments:**

**DISBURSEMENTS**

- 1. Are checks issued in a pre-numbered sequential order and are all check numbers accounted for?
- 2. Are spoiled and voided checks accounted for properly?
- 3. Are disbursements supported by appropriate documentation, (e.g., timesheets, invoices, vender receipts)?
- 4. Are invoices and supporting papers effectively cancelled upon payment?
- 5. Are only authorized personnel signing checks?
- 6. Are banks promptly notified, in writing, when authorized check signers terminate employment with the provider?
- 7. Are the entries in the checkbook complete; i.e., do they include the amount, date of payment, name of payee and purpose?
- 8. Are ledgers/journals reconciled to bank statements on a monthly basis? If not, how often?
- 9. When not in use, are checks locked in a secure cabinet?
- 10. Is it prohibited to make disbursements from cash receipts?
- 11. Based on the review of paid/unpaid bills, does the provider appear to make payment in a timely manner?
- 12. Is there a petty cash fund, under the responsibility of one custodian, reasonable in size and limited as to purpose and amount disbursed?
- 13. Are cash receipts from accounts receivable or other sources commingled with petty cash funds?
- 14. Are disbursements from petty cash documented by approved supporting invoices?

YES <input checked="" type="checkbox"/>	NO <input checked="" type="checkbox"/>

- 15. Are reimbursements to the petty cash fund approved by a person other than the custodian?
- 16. Is the petty cash voucher for reimbursement effectively cancelled at the time of reimbursement to avoid reuse?
- 17. Are petty cash funds reconciled to approved petty cash allowance by a person other than the custodian on a monthly basis? If not, then how often?


**Comments:**

**BUDGET MANAGEMENT**

- 1. Is the contract budget detailed by cost center (if more than one) by source of funds and by expenditure category?
- 2. Does the provider have procedures to ensure that their expenditures are adequately supported by revenue budgeted for that particular purpose?
- 3. Is a monthly comparison made between budget and actual expenditures to avoid incurring obligations in excess of:
  - a) Total funds available for the contract?
  - b) Total funds available for an expenditure category?
- 4. Are amendments to the budget made only with the approval of the top management of the provider?
- 5. When budget revisions cause either the contract terms or dollar amount to change, is written approval from the department obtained prior to making the expenditures authorized in the revised budget?

YES	NO
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**Comments:**

**PERSONNEL MANAGEMENT**

- 1. Are personnel policies written and approved by an appropriate authority?
- 2. Do the personnel policies include a written job description for all positions on file? Does each job description and/or class specification identify:
  - a) Job title?
  - b) Primary responsibilities?

YES	NO
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>



## 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=%7CaW1wb3NpdGlubiBvZiBjaGFyZ2Vz%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*** includes the provision of professional diagnostic and therapeutic services directly to a client by a physician, physician assistant, clinical nurse specialist, nurse practitioner, or other health care professional certified in his or her jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing 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 PHS's guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

**b. *Local AIDS pharmaceutical assistance (APA, not ADAP)*** are local pharmacy assistance programs implemented by Part A and grantees to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g., outpatient/ambulatory medical care or case management) to the clients that they serve through a 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. *Early intervention services*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and 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 provision of therapeutic measures.
- d. *Oral health care*** includes diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide health care in the State or jurisdiction, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained dental assistants.
- e. *Health insurance premium and cost sharing assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain 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 and community based 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.
- g. *Home health care*** is the provision of services in the home by licensed health care professionals, such as nurses, and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.
- h. *Mental health services*** are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They 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. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.
- i. *Medical nutrition therapy***, including nutritional supplements, is provided by a licensed, registered dietitian outside of an outpatient/ambulatory medical care visit. The provision of food may be provided pursuant to the recommendation of a health care professional (i.e., physician, physician assistant, clinical nurse specialist, nurse practitioner) and a nutritional plan developed by a licensed, registered dietitian. Nutritional counseling services and nutritional supplements not provided by a licensed, registered dietitian shall be considered a support service and be reported under psychosocial support services and food bank/home-delivered meals, respectively. Food not provided pursuant to a health care professional's recommendation and a nutritional plan developed by a licensed, registered dietitian should also be considered a support service and is reported under food bank/home-delivered meals.
- j. *Medical case management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services

provided by trained professionals, including both medically credentialed and other health care staff. The coordination and follow up of medical treatments are 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 needs and personal support systems of the client and other key family members. 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, at least every 6 months, as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face meetings, telephone calls, and any other forms of communication.

**k. Substance abuse services (outpatient)** are 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.

**l. Case management services (non-medical)** include 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.

**m. Emergency financial assistance** is the provision of one-time or short-term payments to agencies or the establishment of voucher programs when other resources are not available to help with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), transportation, and medication. Part A and Part B programs must allocate, track, and report these funds under specific service categories, as described under 2.6 in DSS Program Policy Guidance No. 2 (formerly Policy No. 97-02).

It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be the payer of last resort, and for limited amounts, use, and periods of time. Continuous provision of an allowable service to a client should be reported in the applicable service category.

**n. Food bank/home-delivered meals** involves 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 also be included in this item. The provision of food or nutritional supplements by someone other than a registered dietician should be included in this item as well.

Food vouchers provided as an ongoing service to a client should be reported in this service category. Food vouchers provided on a one-time or intermittent basis should be reported in the emergency financial assistance category.

- o. Health education/risk reduction** activities educate clients living with HIV about how HIV is transmitted and how to reduce the risk of transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

Health education/risk reduction services can only be delivered to individuals who are HIV positive. These services cannot be delivered anonymously. Client-level data must be reported for every person who receives these services.

- p. Linguistics services** include interpretation (oral) and translation (written) services, provided by qualified people as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support the delivery of RWHAP-eligible services.

- q. 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.

- r. 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 or HIV prevention education. Broad activities such as providing leaflets at a subway stop, a poster at a bus shelter, or tabling at a health fair would not meet the intent of the law. These services should 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, targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection, conducted at times and in places where there is a high probability of reaching individuals with HIV infection, and designed with quantified program reporting that will accommodate local effectiveness evaluation. RWHAP outreach services cannot be delivered anonymously. Client-level data must be reported for every person who receives this service.

- s. Psychosocial support services** are support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Nutrition counseling services provided by a nonregistered dietitian are reported in this service category.

Nutritional services and nutritional supplements provided by a licensed, registered dietitian are considered a core medical service and should be reported as medical nutrition therapy. The provision of food and/or nutritional supplements by someone other than a registered dietitian should be reported in the food bank/home-delivered meals service category.

t. **Referral for health care/supportive services** is the act of directing a client to a service in person or in writing, by telephone, or through another type of communication. These services are provided outside of outpatient/ambulatory medical care, medical case management, or non-medical case management service visit.

Referrals for health care/supportive services provided by outpatient/ambulatory medical care providers should be included under the outpatient/ambulatory 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 (i.e., medical case management or non-medical case management). Staff who do not provide any case management services but conduct Ryan White core eligibility assessments may utilize this line item.

u. **Substance abuse services (residential)** includes treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term care).

v. **Treatment adherence services** includes counseling or special programs provided outside of a medical case management or outpatient/ambulatory medical care visit by non-medical personnel to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Treatment adherence counseling provided during an outpatient/ambulatory care service visit should be reported under the outpatient/ambulatory medical care service category. Likewise, treatment adherence counseling provided during a medical case management visit should be reported in the medical case management service category.

## 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 <sup>1</sup>
Early Intervention Services	1 client encounter
Oral Health Care	1 visit
Health Insurance Premium/Cost Sharing	1 premium, deductible, or co-payment <sup>2</sup>
Home Health Care	1 visit <sup>3</sup>
Home and Community Based Services	1 client encounter
Mental Health Services - Outpatient	1 client encounter
Medical Nutrition Therapy	1 visit or 1 case of supplement <sup>4</sup>
Medical Case Management (including Treatment Adherence)	1 Medical Case Manager encounter per client per day <sup>5</sup>
Substance Abuse Services - Outpatient	1 client encounter
Case Management (non-medical)	1 Non-Medical Case Manager encounter per client per day <sup>5</sup>
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 <sup>6</sup>
Health Education/Risk Reduction	1 client encounter
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 <sup>7</sup>
Outreach Services	1 client encounter
Psychosocial Support Services	1 individual or group encounter
Referral for Health Care/Supportive Services	1 client encounter per client per day <sup>5</sup>
Substance Abuse Services – Residential	1 day
Treatment Adherence Services	1 client encounter

<sup>1</sup> The unit of service is one prescription for up to 30 days of medication. A prescription written for less than 30 days is counted as one unit. If a prescription is written for more than 30 days, the number of units is the number of days of the prescription divided by 30. Units of service should be reported as whole numbers. For example, a prescription is written for 90 days. The units of service are 90 divided by 30 equals 3 units of service (90/30=3). If a prescription is written for 40 days, 40 divided by 30 equals 1.3 for 2 units of service (40/30=1.3 for 2 units). Any prescription that is for less than one full month should be rounded up to the next whole number for the units of service.

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

<sup>3</sup> The unit of service is one visit by a health care professional to a client's home per day. For example, if a nurse visits a client, begins medical therapy, leaves, and 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.

<sup>4</sup> The unit of service is one visit to a licensed, registered dietician outside of a primary care visit or one case of a nutritional supplement, such as Boost or Ensure. 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.

<sup>5</sup> The unit of service is the sum of unduplicated clients seen or contacted for this service per day. For 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.

<sup>6</sup> 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.

<sup>7</sup> 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 counts as one unit of service.

# APPENDIX G: Florida Department of Health, HIV/AIDS Section Client Complaint, Grievance, and Appeal Procedures

## Introduction

The following procedures apply to programs operated under the auspices of the Florida HIV/AIDS 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 cannot 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 cannot 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 cannot 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 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 H: Contact Information

### Florida Department of Health, HIV/AIDS 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
Joe May	Patient Care Manager	4421	<a href="mailto:Joe.May@flhealth.gov">Joe.May@flhealth.gov</a>
Tracy Smith	Operation Analyst 1	2529	<a href="mailto:Tracy.Smith@flhealth.gov">Tracy.Smith@flhealth.gov</a>

HOPWA			
Name	Title/Function	Ext.	Email Address
Craig Reynolds	State HOPWA Program Coordinator	2539	<a href="mailto:Craig.Reynolds@flhealth.gov">Craig.Reynolds@flhealth.gov</a>
Cheryl Urbas	State Housing Coordinator	2530	<a href="mailto:Cheryl.Urbas@flhealth.gov">Cheryl.Urbas@flhealth.gov</a>

Community Programs			
Name	Title/Function	Ext.	Email Address
Effective 7/5/2016 Shelley Taylor-Donahue	Community Programs Supervisor	2541	<a href="mailto:Shelley.TaylorDonahue@flhealth.gov">Shelley.TaylorDonahue@flhealth.gov</a>
Cheryl Williams	Community Programs Coordinator	2594	<a href="mailto:Cheryl.Williams@flhealth.gov">Cheryl.Williams@flhealth.gov</a>
Meghan Daily	Community Programs Coordinator	2522	<a href="mailto:Meghan.Daily@flhealth.gov">Meghan.Daily@flhealth.gov</a>
VACANT	Community Programs Coordinator	2560	
VACANT	Community Programs Coordinator		

ADAP			
Name	Title/Function	Ext.	Email Address
Jimmy Llaque	ADAP Director	4477	<a href="mailto:Jimmy.Llaque@flhealth.gov">Jimmy.Llaque@flhealth.gov</a>
Steven Badura	Operation & Compliance Manager	2552	<a href="mailto:Steven.Badura@flhealth.gov">Steven.Badura@flhealth.gov</a>
Cherrishe Brown		2549	<a href="mailto:Cherrishe.Brown@flhealth.gov">Cherrishe.Brown@flhealth.gov</a>
Tammy Cuyler	ADAP SW Consultant	2542	<a href="mailto:Tammy.Cuyler2@flhealth.gov">Tammy.Cuyler2@flhealth.gov</a>

Paul MeKeel	Benefits Manager	2504	<a href="mailto:Paul.Mekeel@flhealth.gov">Paul.Mekeel@flhealth.gov</a>
Joseph Cohen	ADAP SW Consultant	2551	<a href="mailto:Joseph.Cohen@flhealth.gov">Joseph.Cohen@flhealth.gov</a>
James Easton	ADAP SW Consultant	2540	<a href="mailto:James.Easton@flhealth.gov">James.Easton@flhealth.gov</a>
Nneka Abara	ADAP SW Consultant	2556	<a href="mailto:Nneka.Abara@flhealth.gov">Nneka.Abara@flhealth.gov</a>

**Reporting Unit (CAREWare help is 850-245-4744, and AIMS 2.0 help is 850-922-7599)**

<b>Name</b>	<b>Position</b>	<b>Ext.</b>	<b>Email Address</b>
Lina Saintus	Reporting and Information Systems Supervisor	4448	<a href="mailto:Lina.Saintus2@flhealth.gov">Lina.Saintus2@flhealth.gov</a>
Cynthia Norris	Reporting Specialist	2525	<a href="mailto:Cynthia.Norris@flhealth.gov">Cynthia.Norris@flhealth.gov</a>
Rhonda Jones	Reporting Specialist	2535	<a href="mailto:Rhonda.Jones@flhealth.gov">Rhonda.Jones@flhealth.gov</a>
Sharon Linzy	Reporting Consultant	2543	<a href="mailto:Sharon.Linzy@flhealth.gov">Sharon.Linzy@flhealth.gov</a>
Eunice Sawaya	Reporting Analyst	2561	<a href="mailto:Eunice.Sawaya@flhealth.gov">Eunice.Sawaya@flhealth.gov</a>





