Chapter 29: Performance Based Contracts and Memoranda of Agreement

Introduction

The following standards support activities that are:

- designated in statute and rule,
- necessary to accomplish implementation as outlined in statute and rule, and
- necessary to establish and maintain a high-level quality of care.

Standards and Criteria

Standard 29.1 All Healthy Start direct services dollars allocated through the Healthy Start coalitions will be dispensed through contracts or memoranda of agreement.

Criteria:

29.1.a All contracts and/or memoranda of agreement entered into between the Healthy Start coalition and providers of direct Healthy Start participant services will contain the specified elements of a performance based contract as described in the Contract Management System for Contractual Services (75AMP2), Section VII.B.

29.1.b The agreed upon performance measures between the Department of Health and the Healthy Start coalition will be incorporated, when appropriate, into contracts and/or memoranda of agreement the coalition enters into with providers of direct Healthy Start participant services.

29.1.c All services purchased through contracts and/or memoranda of agreement will meet the requirements of legislative intent and Department of Health policy and will be provided in accordance with the standards contained in the Healthy Start Standards and Guidelines.

29.1.d All contracts and/or memoranda of agreement entered between the Healthy Start coalition and providers of direct Healthy Start participant services will within 30 days of execution be submitted to the Department of Health and reviewed for required contract and service elements and quality standards.

Background

History of MCH Funding in Florida: In 1977, Maternal and Child Health Improved Pregnancy Outcome funds were originally allocated to fund services to women in five rural counties where prenatal care services were not available. As the program went statewide and all health departments began offering prenatal care services, allocations were based on need factors such as the number of low-income women of childbearing age and the number of births in each county.

The last increase in Maternal and Child Health funds in the Improved Pregnancy Outcome category was approximately $1.1 million in 1987-88. These funds were allocated based on the number of women by county reporting no prenatal care and the number of low birth weight babies by county.

Another source of funds, Aid to Local Government /Improved Pregnancy Outcome, was allocated in 1982 based on need factors such as the number of low-income women of childbearing age and the number of births in each county. The last increase in this funding was approximately $1.35 million in 1988-89. This increase was allocated according to the percentage of total Improved Pregnancy Outcome funding the county health department received in the 1987-88 allocation.

Healthy Start funds (initially identified as “enhanced services funds”) were initially allocated in the last quarter of FY 1991-92 based on a formula weighted 65 percent on the number of high risk prenatal cases and 35 percent on the number of high risk postnatal (infant) cases identified through Healthy Start screening. New Healthy Start funds appropriated in FY 1992-93 and FY1993-94 were allocated based on the same formula as above. Base funding, the amount of funds provided in the previous year, was provided in the same amounts each successive year. Only new funds were allocated by formula.

In FY 1994-95, the formula was modified and new funds were allocated based on a formula weighted 65 percent on the number of high risk prenatal cases, 30 percent on high risk postnatal cases, 2.5 percent on county land area and 2.5 percent on price level differentials. This same formula was used to distribute the FY 1995-96 Healthy Start increases.

In 2006 and 2007, new Healthy Start funds appropriated by the legislature, were allocated based on the “Zimmerman method”, 1% to all coalition catchment areas and the remaining funds according to the proportion of the current base funding.

A Healthy Start Allocation Workgroup, established in 2002, consisting of representatives from the Department of Health, the Florida Association of County Health Officers and the Florida Association of Healthy Start Coalitions was convened to revisit the formula for allocation of Healthy Start funding. This workgroup is currently active and is working toward a revised allocation methodology for Healthy Start direct service funds.

Funding for Community Based Prenatal and Infant Health Care Coalitions planning and administration began in FY 1992-93. Each coalition receives an annual amount of up to $150,000 through contract with the Department of Health, which is the cap set under s. 383.216, F.S. This includes $87,500 in General Revenue and $67,500 in Medicaid administrative match.

Current Funding for MCH in Florida: The Healthy Start coalitions annually determine how all Healthy Start funds appropriated for Healthy Start women and children and direct service dollars appropriated under the Improved Pregnancy Outcome and Child Health (under age 1) budget appropriation categories are used in each of their service delivery areas. The coalitions award these funds through a memorandum of agreement (MOA) with the county health department or through a contract with the county health department or any other qualified provider or combination of providers.

Section 20.19 (1)(b), F. S., requires the department to create a five-year strategic plan that establishes a set of measurable goals and objectives and operational performance standards. Effective July 1,1996, all contracts entered into by the department must contain a set of measurable and objective performance standards by which the contract provider's performance will be evaluated. The requirements for these performance- based contracts are outlined in Section VII.B. of the Contract Management System for Contractual Services (75AMP2).

Medicaid Waiver Funding: In 2001, the State of Florida, Department of Health, was awarded a Section 1915 (b)(1) Healthy Start Medicaid Managed Care waiver under the Medipass Program. This waiver consists of two components: care management of women eligible for Medicaid due to their pregnancy (MomCare program); and Healthy Start services for an increase in the duration and intensity of service provision to Healthy Start women and children.

Healthy Start coalitions can administer the MomCare Program, contract with county health departments, or, on approval of the Department of Health, may contract with other providers for the provision of these services. If the coalition decides to contract these services to a county health departments or community provider, the performance measures, tasks, and deliverables must be passed on to the contracted provider to assure that departmental reports and deliverables can be met.

The increase in duration and intensity of services to Healthy Start women and children is the basis behind the 2001 changes that occurred in the Healthy Start Standards and Guidelines. The waiver states both desired specific cost savings for the State and also addresses desired positive programmatic outcomes in such areas as:

- Adequacy of prenatal care
- Percent of pregnant women and new mothers who smoke
- Percent of infants born at less than 37 weeks
- NICU admissions
- Infant Mortality Rate
- Breastfeeding initiation and continuity rates
- Access to well child care
- Immunization rates for children under 3

Responsibility

Required areas to be included in coalition performance based contract or MOA:

A. Outreach

All standards described in the *Healthy Start Standards and Guidelines*, Chapter 27, must be listed or referenced. Responsibilities for each of the components of outreach should be specified.

B. Prenatal and Well Child Clinical Care

Reference should be made to standards of care for prenatal and well child medical care. A statement that prenatal and child health care should be provided with Healthy Start funds only if there are no other sources of payment (e.g., Medicaid, insurance, county funds) should be included in each coalition performance based contract or MOA.

C. Healthy Start Prenatal and Postnatal Screening

The county health department responsibilities as outlined in rule 64F-3.002, F.A.C., must be listed as well as all standards described in the *Healthy Start Standards and Guidelines*, Chapter 3.

A statement should be included that indicates that the designated agency for Healthy Start care coordination must report on a regular basis to the Healthy Start coalition the names of the providers in the community who need to improve their screening rates.

A statement should be included when the Healthy Start coalition delegates an entity to engage in activities to encourage an increased rate of screening in the community, such as visiting providers, providing education about Healthy Start screening to providers and the community, and following up on providers who are not screening.

D. Healthy Start Care Coordination

All standards described in the *Healthy Start Standards and Guidelines*, Chapter 4 Coordinated Intake and Referral and Chapter 6 The Healthy Start Program, must be listed or referenced.

The following are examples of performance measures:

- At least 90 % of Healthy Start participants will receive an Initial Contact, or an attempt to contact, within 5 working days of receipt of screen.
- At least 80 % of Healthy Start participants determined to be in need of an Initial Assessment will receive an Initial Assessment, or an attempt to assess, within 10 working days of an initial contact.
- At least 80 percent of the participants in the educational components of Healthy Start services will demonstrate increased knowledge as indicated on periodic pre and post tests for group or class efforts.

E. Healthy Start Services

All standards described in the *Healthy Start Standards and Guidelines*, Chapters 4-22 must be listed or referenced. This will include qualifications of specific staff identified in the relevant chapters of the *Healthy Start Standards and Guidelines*.

The following is an example of a performance measure:

- At least 50 percent of participants that start classes complete them.

F. Quality Management (QM)/Program Improvement (PI) Evaluation

All standards described in the *Healthy Start Standards and Guidelines*, Chapter 30, must be listed or referenced.

A statement must be added that indicates the provider acknowledges and agrees that its performance under this contract or MOA must meet the specified standards contained in the contract or MOA, and that, if the provider fails to meet those standards, the coalition, at its exclusive option, may allow a specified time period for the provider to achieve compliance with the standards. If the coalition affords the provider an opportunity to achieve compliance and the provider fails to achieve compliance within the specified time period, the coalition reserves the right to terminate the contract in the absence of any extenuating or mitigating circumstances.

A statement must be included assuring that the contracted Healthy Start service provider has an internal QM/PI system in place. The provider will report these findings to the coalition on a quarterly basis.

Language should be included that outlines a grievance procedure for contracted providers in the event that they have grievance with the coalition.

Language must be included that describes the manner in which the contract or MOA will be monitored and evaluated and which reports, records, and documents will be used in conducting the evaluation. There must be a statement that describes Quality Management/Program Improvement (QM/PI) activities to be conducted, how often they will be conducted, and by whom. It is recommended that on-site monitoring be done no less frequently than once a year. The coalition will assure that each provider has a functioning QM/PI process by conducting programmatic monitoring at least once a year and more frequently if deemed appropriate.

A statement must be included that describes how follow-up will be accomplished through the submission of a performance improvement plan, particularly in the event that the provider fails to meet the performance standards.

G. Reporting

Provision should be made for providing documentation to verify that funds expended were for Healthy Start services. Existing state reports can be used to meet this requirement when reports are determined to be timely (within 45 days) and accurate. The coalition and the provider should negotiate which reports will be necessary in the event that state reports are not available. In the event that this should occur, the coalition and provider will negotiate any necessary locally generated reports and the costs incurred with producing them.

All standards described in the *Healthy Start Standards and Guidelines*, Chapter 25, must be listed or referenced.

H. Enforcement

Provider reports should be reviewed on a quarterly basis or more frequently if a performance improvement plan has been initiated.

References

Section 383.011, F.S., Administration of Maternal & Child Health Programs

Section 383.14, F.S., Screening for Metabolic Disorders, Other Hereditary and Congenital Disorders, and Environmental Risk Factors

Section 383.216, F.S., Community-based Prenatal and Infant Health Care

Chapter 64F-3, F.A.C., *Healthy Start Care Coordination*

Chapter 64F-2, F.A.C., *Healthy Start Coalitions*

Chapter 64C-7, F.A.C., *Prenatal and Postnatal Risk Screening and Infant Screening for Metabolic, Hereditary, and Congenital Disorders*

Contract Management System for Contractual Services (75AMP2), Section VII.B., Performance Contracting

Work Statement Format Performance Based Contract

Sample Performance Based Contract

Sample Performance Based Memorandum of Agreement

Frequently Asked Questions

Q. ***Are there other fiscal issues, aside from the accountability issue, that providers and coalitions should address while negotiating MOAs or contracts?***

A. Yes, there is a series of questions that should be asked.

- Are services being delivered in timely fashion so that no lapse of funds will occur? If not, what needs to change: funding mechanism? Number of providers? Recruitment? Follow-up?
- Can excess monies be rolled over at the end of the contract/MOA, and if so, how are monies tracked that are rolled over from one fiscal year to the next?
- What breaches of contract are sufficient for the coalition board to cancel the contract?
- Are the charges built into the contract/MOA sufficient to cover the total cost of providing the service (including infrastructure) and build in a reasonable margin of profit?
- Can other providers in the community deliver equal quality of service for a lower price?
- Are some providers' proposed rates out of line with other bidders? If too low or too high, are they calculating their costs and charges correctly? (The business acumen represented on coalition boards and staffs can assist providers in setting rates that accurately reflect their direct and allocated costs as well as a

reasonable margin of profit.)

Q. ***Must contractors use the existing Department of Health Healthy Start reports, the Executive Summary and the GH 330 report, if they answer the fiscal questions?***

A. Yes. If the provider or contractor feels the reports are in error, they must document the error and work with the state and provider to find the source of the error so it can be corrected.

Q. ***How can HS care coordination providers comply with reporting requirements if Healthy Start reports are late or incorrect?***

A. Contract managers should not penalize HS care coordinators for not providing information they cannot access. The Department of Health must notify coalitions and county governments, both having fiduciary responsibilities to monitor contracts, when expected data reports are late or are incorrect.

Q. ***If a provider sees more participants than projected in the contract/MOA, will he be paid additional dollars?***

A. It is a local decision that must be spelled out in the terms of the contract/MOA. Regular tracking on the part of the provider of any discrepancy between the number of services anticipated and the actual number being provided may warrant negotiations for a contract amendment.

NOTES: