

**2020-2021
Patient Care
Program
Administrative
Guidelines**



December 2019

2020–2021 Patient Care Program Administrative Guidelines

Table of Contents

Section 1: Introduction	3
A. Purpose of the Guidelines	3
B. Roles and Responsibilities: Florida Department of Health (FDOH) HIV/AIDS Section	3
C. Roles and Responsibilities: Contracted Lead Agencies	4
D. Roles and Responsibilities: County Health Department (CHD) Lead Agencies	5
E. Lead Agency Policies	6
F. Ryan White Part B Local Planning Groups	7
G. Payer of Last Resort	8
Section 2: Contract Procedures, Limitations, and Restrictions	9
A. Eligibility for Services	9
B. Subcontractors	9
C. Non-Medical and Medical Case Management	10
D. AIDS Pharmaceutical Assistance and Emergency Financial Assistance	12
E. CAREWare Requirements	12
F. Fee for Service	13
G. Limitations and Restrictions for Core Medical and Support Service Categories	14
H. Vital Status	16
Section 3: Contract Budget	18
A. Budget Categories	18
B. Subcontract Budgets	24
C. Budget Revisions	24
D. Quarterly Financial Report (QFR)	26
Section 4: Contract Monitoring	27
A. Monitoring Lead Agencies	27
B. Monitoring Subcontracted Providers	28
C. Monitoring Memorandums of Agreement (MOA)/Memorandums of Understanding (MOU), PurchaseOrders, and Other Provider Agreements	29
D. Health Resources & Services Administration (HRSA) Monitoring Standards	30
Section 5: Reporting Requirements	31
A. Reporting Overview	31

B. Report Submission	31
Appendix A: Resources	34
Appendix B: FDOH HIV/AIDS Section Patient Care Administered Programs/Funding Streams	36
Appendix C: Glossary of Acronyms and Terms	38
Appendix D: FDOH HIV/AIDS Section, Client Complaint, Grievance, and Appeal Procedures	41
Appendix E: Allowable Service Definitions	45
Appendix F: Requirements Regarding Imposition of Charges for Services	55
Appendix G: Units of Service Definitions	57
Appendix H: Prohibited Expenditures in the Reference Guide for State Expenditures	59
Appendix I: Required Travel Forms	60
Appendix J: Budget Summary Template	63
Appendix K: Administrative Assessment	64

Section 1: Introduction

The FDOH, HIV/AIDS Section, administers a variety of HIV patient care programs with different funding streams. The funding streams that are applicable to these guidelines are:

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

A brief explanation of each of these programs is found in Appendix B. A glossary of acronyms and terms used in this guidance is included as Appendix C. The requirements set forth in this document are effective April 1, 2020 for Ryan White Part B funding, and July 1, 2020 for GR and PCN funding.

A. Purpose of the Guidelines

These guidelines were written for both contract managers and lead agencies, and they detail the roles and responsibilities of each. Contract managers will also find guidance on preparing and monitoring lead agency contracts. For lead agencies, the guidelines describe the provisions of lead agency contracts and the requirements for subcontracts and subcontractor monitoring.

These guidelines apply to both Ryan White Part B and GR PCN funding. The guidelines and any referenced manuals may be updated to provide the most accurate and comprehensive information available. It is the contract manager's and the lead agency's responsibility to ensure compliance with all updated guidelines and referenced manuals.

B. Roles and Responsibilities: FDOH HIV/AIDS Section

FDOH is the grantee of HRSA's Ryan White Part B Program for the state of Florida. The HIV/AIDS Section's Patient Care Program is responsible for the management of this statewide program. As the grantee, FDOH provides funding statewide to Florida's Ryan White Part B HIV care programs. FDOH employs HIV/AIDS program coordinators (HAPCs) and contract managers throughout the state to coordinate, provide oversight for, and facilitate activities in their assigned areas, including accessing Provide Enterprise, CAREWare, the Health Management System (HMS), the AIDS Information Management System (AIMS), and other local data collection systems as needed to investigate client issues. FDOH enters into agreements with lead agencies to provide services to persons living with HIV (PLWH) in compliance with program requirements.

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

- Acting as fiscal administrator of all HIV patient care funds.
- Coordinating statewide policy and procedures.
- Ensuring compliance with all HIV patient care requirements, which include all guidelines and referenced manuals.
- Ensuring Ryan White Part B and PCN are payers of last resort.

- Ensuring the health and well-being of Floridians by providing access to HIV patient care and support services.
- Ensuring Ryan White Part B lead agencies conduct needs assessments, prepare service plans, and coordinate service provisions.
- Facilitating statewide meetings.
- Monitoring and auditing HIV patient care activities.
- Preparing and reviewing Ryan White Part B and GR contracts.
- Preparing and submitting the statewide Ryan White Part B grant application to HRSA.
- Providing technical assistance.
- Responding to all federal and state programmatic and reporting requirements.

C. Roles and Responsibilities: Contracted Lead Agencies

Ryan White Part B and GR contracted lead agencies play an essential role in providing patient care and support services to PLWH. FDOH enters into contractual agreements with lead agency organizations that may subcontract with other service providers.

The roles and responsibilities of a contracted lead agency include, but are not limited to:

- Acting as data coordinator for the contracted providers for each county within their area.
- Acting as fiscal administrator of Ryan White Part B and GR funds.
- Adhering to reporting requirements, as defined by state and federal governments, and any subsequent changes to these requirements enacted during the program year.
- Administering needs assessments as required.
- Developing emergency procedures in preparation for disasters.
- Developing and executing subcontracts, MOA/MOU, purchase orders, and other provider agreements.
- Developing local service delivery guidelines with service limits.
- Ensuring client satisfaction surveys are conducted and reviewed.
- Participating in the development of the local Integrated HIV Prevention and Care Plan with the local planning group.
- Ensuring data is entered into CAREWare.
- Ensuring subcontracts comply with the primary contract. Contract managers should always check the Office of Contracts' SharePoint site to ensure that the correct forms are being used.
- Ensuring that training and technical assistance resource materials are available to local planning group members (Ryan White Part B only).
- Ensuring the clinical quality management (CQM) plan aligns with the goals of the current State of Florida Integrated HIV Prevention and Care Plan and those of the Department's HIV/AIDS Section.
- Facilitating 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 FDOH policy DOHP 250-9-14.
- Maintaining and submitting (upon request) back-up documentation for all expenditures charged to either Ryan White Part B or GR as reported in AIMS.
- Maintaining local planning group files (Ryan White Part B only).

- Monitoring MOA, MOU, purchase orders, and other provider agreements for programmatic standards and agreement deliverables.
- Monitoring subcontractors.
- Organizing local planning group mailings (Ryan White Part B only).
- Processing invoices from subcontractors.
- Providing administrative support to the local planning group and promoting consumer involvement (Ryan White Part B only).
- Providing technical assistance to subcontractors.
- Registering with the Florida Department of State, Division of Corporations, database. The Division of Corporations is the state of Florida's official business entity index and commercial activity website.
- Reimbursing subcontractors.
- Signing primary Ryan White Part B and GR contracts with FDOH.
- Submitting program and financial reports to the HIV/AIDS Section.

D. Roles and Responsibilities: County Health Department Lead Agencies

In some areas of the state, the CHD serves as the lead agency. For these CHD lead agencies, FDOH puts the funding on the Schedule C. The CHDs prepare and submit HIV 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 agencies are subject to the same programmatic and monitoring requirements as other lead agencies. Community programs coordinators monitor Schedule C requirements.

The roles and responsibilities of a CHD lead agency include, but are not limited to:

- Acting as data coordinator for the contracted providers for each county within their area.
- Acting as fiscal administrator of Ryan White Part B and PCN funds.
- Adhering to reporting requirements, as defined by state and federal governments, and any subsequent changes to these requirements enacted during the program year.
- Administering needs assessments as required.
- Assuming full responsibility for all aspects of the continuum of care for each county within their area.
- Developing emergency procedures in preparation for disasters.
- Developing and executing subcontracts, MOA/MOU, purchase orders, and other provider agreements.
- Developing a local Integrated HIV Prevention and Care Plan with the local planning body (Ryan White Part B only).
- Developing local service delivery guidelines with service limits.
- Ensuring client satisfaction surveys are conducted and reviewed.
- Ensuring data is entered into CAREWare.
- Ensuring subcontracts comply with FDOH Standard Contract and Attachment I. Contract managers should always check the Office of Contracts' SharePoint site to ensure that the correct forms are being used.
- Ensuring that training and technical assistance resource materials are available to local planning group members (Ryan White Part B only).

- Facilitating 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 FDOH policy DOHP 250-9-14.
- Maintaining and submitting (upon request) back-up documentation for all expenditures charged to either Ryan White Part B or PCN as reported in the Financial Information System and AIMS.
- Maintaining local planning group files (Ryan White Part B only).
- Monitoring subcontractors and outlying county health departments that receive Ryan White Part B Consortia funds and/or GR PCN funds.
- Monitoring MOA/MOU, purchase orders, and other provider agreements for programmatic standards and agreement deliverables.
- Organizing local planning group mailings (Ryan White Part B only).
- Processing invoices from subcontractors.
- Providing administrative support to the local planning group and promoting consumer involvement (Ryan White Part B only).
- Providing technical assistance to subcontractors.
- Reimbursing subcontractors.
- Submitting program and financial reports to the HIV/AIDS Section.

E. Lead Agency Policies

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

- Bylaws and board policies (if applicable) regarding:
 - Charges for copying documents.
 - Public access to records that are exempt.
 - Timeframes for providing documentation or procedures for denying access to documentation.
 - Types of records that must be produced.
- Eligibility and clinical policies to ensure that providers:
 - Classify veterans receiving Veterans Affairs health benefits as uninsured, thus exempting these veterans from the “payer of last resort” requirement.
 - Do not deny HIV services due to non-HIV-related conditions (primary care).
 - Do not deny services due to pre-existing conditions.
 - Do not provide any other barrier to care due to a person’s past or present health condition.
- Financial policies and procedures that cover:
 - 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, including:
 - Current fee schedule and schedule of charges.

- Policy for imposition of charges that meets HRSA's sub-recipient requirements for imposition of charges.
- Process for determining client charges and caps on charges, charging the client, documenting and periodically updating the client's ability to pay, documenting charges assessed, and tracking income from charges paid, through a manual or electronic information system.
- Determining allowable and reasonable costs.
- Guiding selection of an auditor.
- Handling Ryan White Part B or GR revenues, including program income.
- Local area service delivery guidelines with service limits.
- Personnel policies, including:
 - Adequate policies and procedures to discourage soliciting cash or in-kind payments for awarding agreements (including contracts), referring clients, and/or purchasing goods or services.
 - Conflict of interest policy that covers the procurement and contract management process as well as the processes of the local planning group.
 - 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 Ryan White Part B and PCN are the payers of last resort and how to meet that requirement.
 - 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, including:
 - Client complaint, grievance, and appeal procedures (refer to Appendix D for details).
 - Code of ethics or standards of conduct.
 - 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.
 - A policy that forbids the use of Ryan White Part B and GR funds for cash payments to service recipients.
 - A policy on providing transportation (either by referral or vouchers) if the facility is not accessible to public transportation.

F. Ryan White Part B Local Planning Groups

Local planning groups advise the HIV/AIDS Section on planning and prioritizing the use of Ryan White Part B funds. Local planning groups must include PLWH; provide a forum for community stakeholders, providers, and others; and facilitate the provision of coordinated, comprehensive health and support services to PLWH.

The activities of HIV local planning groups generally fall under the following categories:

- Capacity development
- Comprehensive planning
- Coordination
- Priority setting

- Service delivery

The activities of the local planning group include, but are not limited to:

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

G. 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 federal entitlement programs, prepaid health plans, and private insurance. It is therefore incumbent upon providers to ensure that eligible individuals are promptly enrolled in Medicaid and that funds are not used to pay for any Medicaid-covered services for Medicaid enrollees. It is also important to ensure that providers pursue Medicaid and other third-party payment when covered services are provided to beneficiaries of other programs. For example, if an applicant is eligible for Medicaid, the provider should retroactively bill Medicaid for services provided during the time that eligibility was being determined.

In areas where other HIV funding, such as GR, PCN, or HOPWA, is available, Ryan White Part B does not require that each of these funding sources be exhausted prior to accessing Ryan White 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, HAPC, and community programs coordinator.

Section 2: Contract Procedures, Limitations, and Restrictions

A. Eligibility for Services

All clients receiving services from Ryan White Part B Consortia, PCN, or other programs administered by the FDOH HIV/AIDS Section (including ADAP, HOPWA, and Ryan White Part B Emerging Communities), 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 and/or Provide 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 determining the eligibility to ensure that this process is done correctly.

B. Subcontractors

If the lead agency elects to subcontract for services under their contract, the following guidelines must be adhered to:

- All subcontracts must contain language and restrictions like the primary contract, including scope of work, which contains key activities/services to be rendered, and documentation required to substantiate the delivery of services.
- All subcontracts must model the Ryan White Part B or GR lead agency contract.
- Contract managers are required to save all lead agency subcontractor agreements written for Ryan White Part B and GR funds, along with the corresponding budget documents, to the contracts folder of the share drive within 10 days of receipt from the lead agency.
- Contract managers are required to save all lead agency subcontractor monitoring reports to the contracts folder of the share drive within 10 days of receipt from the lead agency.
- Lead agencies are required to enter into, renew, amend, and/or maintain all subcontractor agreements necessary to provide contract services and submit to the contract manager within 15 days of contract execution and/or renewal of the primary contract.
- Lead agencies are required to submit all additional subcontractor agreements written for Ryan White Part B and GR funds that are executed during the contract term to the contract manager within 10 days of the subcontractor agreement's execution.
- Lead agencies are required to submit all subcontractor monitoring reports to the contract manager within 30 days of completion of the on-site subcontractor monitoring visit.
- Lead agencies are required to submit subcontractor information when setting up their contracts in AIMS.
- Lead agencies are required to use the current budget summary template (without modification) provided by the FDOH HIV/AIDS Section for all subcontractors.
- Lead agencies not providing in-house case management are required to competitively procure non-medical and medical case management services. This process is based on FDOH policy DOHP 250-9-14.
- Subcontracted services and payment for subcontracted services cannot begin prior to the execution of a signed subcontractor agreement.

- Subcontractors must not further subcontract out services without express written approval from the community programs coordinator, community programs supervisor, and Patient Care Program manager.
- Subcontracts must not be executed prior to execution of the primary contract between the lead agency and FDOH.
- Subcontracts must not extend beyond March 31 for Ryan White Part B funded agreements or June 30 for GR funded agreements, in any given grant year.

Please Note: It is recommended that contract negotiations begin three to four months prior to the beginning of the contract year so there is no delay in services.

C. Non-Medical and Medical Case Management

The *Florida Department of Health HIV Case Management Guidelines* provide operating guidelines for case management service providers funded by the FDOH HIV/AIDS Section. Lead agencies not providing in-house case management must comply with the competitive procurement requirement and ensure that subcontracted agencies comply with the training and monitoring requirements established by the FDOH HIV/AIDS Section. Lead agencies that subcontract for case management are responsible for disseminating all case management policies, procedures, and documents that are created and/or revised by the FDOH HIV/AIDS Section to their providers.

Non-Medical Case Management provides coordination, guidance, and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services. **Please note: Effective October 1, 2019, the HIV/AIDS Section limits the use of the non-medical case management service category to fund eligibility specialists only. All eligibility staff should be funded exclusively under non-medical case management. For further clarification and definitions, refer to the *Florida HIV/AIDS Ryan White Part B Eligibility Procedures Manual* at floridaaids.org/patient-care/documents/eligibility-information/eligibility-manual-6-28-16-c.pdf.**

Positions that have responsibilities spanning the non-medical case management and medical case management service categories should be split-funded based on the proportion of time spent on each. If a staff member does both eligibility determination and case management, the time spent on duties associated with eligibility determination should be funded under non-medical case management, and time spent on duties associated with case management should be funded under medical case management.

Medical Case Management has the goal of improving client health outcomes in support of the HIV care continuum, which is achieved by the provision of a range of client-centered activities. Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical case management includes all types of case management encounters (e.g., face-to-face, over-the-phone).

Key activities of medical case management include:

- Initial comprehensive assessment of service needs.
- Development of a comprehensive, individualized care plan.
- Timely and coordinated access to medically appropriate levels of health, prevention, and support services and continuity of care.

- Continuous client monitoring to assess the efficacy of the care plan.
- Re-evaluation of the care plan at least every six months, with adaptation as necessary.
- Ongoing assessment of the client's and the client's key family members' needs and personal support systems.
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments and to ensure an understanding of the importance of compliance with medical appointments for monitoring.
- Client-specific advocacy and/or review of service use.

In addition to providing the medically oriented activities above, medical case managers may provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, pharmaceutical manufacturer patient assistance programs, other state or local health care and supportive services, and insurance plans through the Health Insurance Marketplace/Exchange).

Section 3 of the *Florida Department of Health HIV Case Management Guidelines* describes staff qualification requirements; minimum required staff training, which must be completed within six months of hire and documented in personnel files; and the minimum roles and responsibilities for case managers and case management supervisors funded under the medical case management service category.

Case management represents a large portion of the FDOH HIV/AIDS Section Patient Care Program's 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 and adhere to the requirements of a case manager as defined in the *Florida Department of Health HIV Case Management Guidelines*. **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 assessing eligibility, their salaries should be proportionally divided between the medical and non-medical case management service categories.

The caseload of a case management supervisor is the combined caseload of all supervised staff. At a minimum, case management supervisors perform the following tasks:

- Conducting interdisciplinary team meetings and/or facilitating meetings with partnered providers regarding client-specific issues.
- Conducting monthly chart reviews for quality management.
- Evaluating staff.
- Filling in for staff members out of the office due to sick leave, annual/vacation leave, etc.
- Hiring and terminating staff.
- Training staff.

Refer to Appendix E for allowable service definitions.

D. AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance (APA) provides medication assistance when ADAP has a restricted formulary, a waiting list, and/or restricted financial eligibility criteria. Lead agencies funding the APA service category must establish the following:

- Uniform benefits for all enrolled clients throughout the service area.
- A recordkeeping system for distributed medications.
- An APA advisory board.
- A drug formulary approved by the local advisory committee/board.
- A drug distribution system.
- A client enrollment and eligibility determination process that includes screening for ADAP and APA eligibility, with rescreening at least every six months.
- Coordination with Florida's Ryan White Part B ADAP. A statement of need should specify the restrictions of Florida's ADAP and the need for APA services at the local level.
- Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program.

Emergency Financial Assistance (EFA) provides limited, one-time, or short-term payments to assist eligible clients with an urgent need for essential items or services necessary to improve health outcomes, including utilities, housing, food (groceries and food vouchers), transportation, or medication not covered by ADAP or the APA service category. Additionally, the EFA service category may be used to provide limited, one-time, or short-term payments to assist clients with an urgent need to pay for allowable costs required to improve health outcomes that are associated with other approved service categories. EFA **must** occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are **not** permitted.

It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of funds to the EFA service category will be as the payer of last resort and for limited amounts, uses, and periods of time. EFA funds used to pay for otherwise allowable services on a short-term basis must be accounted for under the EFA service category. Continuous provision of an allowable service to a client **must not** be funded under the EFA service category.

Please note: APA funds may not be used for EFA services, whereas EFA may assist with medications not covered by the APA service category.

E. CAREWare Requirements

HAPCs and contract managers must be granted viewing rights to all instances of CAREWare within their geographic area to coordinate, provide oversight for, and investigate client issues. Lead agencies must ensure that patient care services paid for by Ryan White Part B, GR, and/or PCN are captured in the CAREWare system for reporting purposes in accordance with the *CAREWare User Manual*. The FDOH 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* and the *Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual*.

F. Fee for Service

“Imposition of charges” is a term used to describe all activities, policies, and procedures related to assessing patient charges as outlined in federal legislation. No patient shall be denied service due to an individual’s inability to pay. Nor shall any patient that fails to pay be turned over to debt collection agencies. However, the imposition of a \$1 flat rate per unit of service charge must be assessed to all eligible Ryan White Part B and PCN clients who are >100% of the federal poverty level (FPL). The imposition of charges is prohibited for all eligible Ryan White Part B and PCN clients who are ≤100% of the FPL.

Funds cannot be used for client no-show fees or fees charged by a service provider when a Ryan White Part B or PCN client did not give prior notice for appointment cancellation. Ryan White Part B and PCN funds are for payment of services rendered.

Lead agencies must maintain policies requiring funded providers who deliver services typically billable to public and private health plans to maintain policies and procedures on client charges. Providers of APA programs, home and community-based health services, home health care, medical nutrition services, mental health services, oral health services, outpatient/ambulatory health services, substance abuse treatment services (inpatient and outpatient), housing, linguistic services, and medical transportation services are considered to provide billable services.

All providers that deliver these billable services with Ryan White Part B and/or PCN funds must develop a \$1 nominal fee program that includes the following:

- A schedule of fees for services.
- A system/policy to track and reconcile fees to assure receipt of care.
- Limitations on annual aggregate charges (cap on charges) based on HIV-positive clients' individual incomes. "Aggregate charges" applies to annual charges imposed for all services, regardless of terminology (i.e. enrollment fees, premiums, deductibles, cost-sharing, co-payments, coinsurance, etc.) and applies to all service providers from whom individuals receive services.
- Policies that prohibit refusal of services to clients who are unable to pay fees or who refuse payment of fees.

Clients cannot be charged more than the maximum amount (cap on charges) in a calendar year. Lead agency policies must specify that once a client’s annual aggregate charges reach the cap, no additional client charges may be made. The cap on charges is based upon HIV-positive clients’ individual modified adjusted gross incomes, as follows:

- 5% for patients with incomes between 101% and 200% of the FPL.
- 7% for patients with incomes between 201% and 300% of the FPL.
- 10% for patients with incomes greater than 300% of the FPL.

All fees assessed for services must be tracked for the client so that any provider that receives any Ryan White Part B and/or PCN funding can ensure that caps on client charges are maintained. All fees collected from any client with the ability to pay are classified as program income and must be reinvested into the program during the same funding period. Refer to Appendix F for details regarding imposition of charges, and refer to Appendix G for information on how to calculate unit(s) of service per service category.

G. Limitations and Restrictions for Core Medical and Support Service Categories

Developing local area service delivery guidelines that include limits for services is a lead agency responsibility. Lead agencies' service delivery guidelines must include all local, state, and federal limitations and/or restrictions for core medical and support service categories. These service delivery guidelines must be made available to current and new Ryan White Part B and PCN clients upon request for clarification of services. In addition to locally determined limitations, state and federal restrictions have been placed on core medical and support services as indicated below.

Core Medical Services

- **APA** is restricted to maintenance medications that are not available through the Ryan White Part B ADAP and:
 - Adhere to local service delivery guidelines, ensuring uniform benefits for all clients.
 - Are distributed and recorded systematically.
 - Are part of a drug formulary approved by a pharmaceutical advisory board.
 - Are reimbursed at 340B pricing.
- **Early Intervention Services (EIS)** must be provided as a combination of services rather than stand-alone testing, referral, linkage, or outreach services. The targeted testing component cannot supplant testing efforts paid for by other sources. Outreach services and health education/risk reduction services are restricted to those related to a client's HIV diagnosis.
- **Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals** that is not related to stand-alone dental insurance assistance is restricted to health care coverage that incorporates the following minimum requirements:
 - Includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' (HHS) *Clinical Guidelines for the Treatment of HIV* as well as appropriate HIV outpatient/ambulatory health services.
 - Proves cost-effective in the aggregate versus paying the full cost for medications and other appropriate HIV outpatient/ambulatory health services.

The use of Ryan White Part B or PCN funds for stand-alone dental insurance premium assistance is limited to lead agency implementation of a methodology that incorporates a requirement to assess and compare the aggregate cost of paying for the stand-alone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing stand-alone dental insurance is cost-effective in the aggregate. Lead agencies must either allocate funding to dental insurance premiums or to oral health care services.
- **Home and Community-Based Health Services** are limited to services based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. These services are restricted from being provided in inpatient hospitals, nursing homes, and other long-term care facilities.
- **Home Health Care** is limited to clients that are homebound, as defined by Centers for Medicare and Medicaid Services. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.
- **Medical Case Management, Including Treatment Adherence Services**, has the goal of improving client health outcomes. The FDOH HIV/AIDS Section has determined that all case management services must be provided under this service category.

- **Medical Nutrition Therapy** must be pursuant to a medical provider's referral and based on a nutritional plan developed by a registered dietitian or other licensed nutrition professional. A prescription and plan of care or chart note from the medical provider can be substituted in cases where a dietician or nutrition professional is not reasonably accessible.
- **Mental Health Services** must be based on a treatment plan and provided by a mental health professional licensed or authorized within the state to render such services.
- **Oral Health Care** services are limited to those provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.
- **Outpatient/Ambulatory Health Services** have the following restrictions:
 - Emergency room visits are not allowable costs.
 - Non-HIV-related visits to urgent care facilities are not allowable costs.
- **Substance Abuse Outpatient Services** limits acupuncture therapy to when it is provided as part of a substance use disorder treatment program funded under Ryan White Part B or PCN and it is included in a documented plan.

Support Services

- **EFA** is limited to one-time or short-term payments to assist a client with an urgent need for essential items or services necessary to improve health outcomes.
- **Food Bank/Home Delivered Meals** are limited to a capped monthly allowance per client, as specified in local service guidelines, after identifying and using all available resources first. Services are meant to supplement, not supply all dietary needs, and are inclusive of all allowable costs:
 - Grocery vouchers that restrict the purchase of unallowable items. Vouchers cannot be exchanged for cash or used for anything other than the allowable goods or services. Systems must be in place to account for disbursed vouchers.
 - Non-food and/or food items meeting specified restrictions and limitations from a food pantry.
 - Non-food items that are limited to personal hygiene products, household cleaning supplies, and water filtration/purification systems in communities where issues of water safety exist.
 - The local rate for home delivered meals.
- **Health Education/Risk Reduction** is limited to clients living with HIV and cannot be delivered anonymously.
- **Housing** services provided under Ryan White Part B or PCN funding are limited to when a client is not qualified for the Florida State HOPWA Program or when Florida State HOPWA Program funds have been exhausted.
- **Linguistic Services** are limited to activities provided by qualified linguistic providers to facilitate communication between the health care provider and the client as required to support delivery of eligible services.
- **Medical Transportation** restricts the use of Ryan White Part B and PCN funds for the following:
 - Direct cash payments or cash reimbursements to clients.
 - Direct maintenance expenses (tires, repairs, etc.) for a privately-owned vehicle.
 - Any other costs associated with a privately-owned vehicle, such as lease or loan payments and insurance, license, or registration fees.Gasoline cards may be used for medical and health-related appointments in circumstances where public and other transportation options are not available. A signed

client usage agreement and/or printed message on the cards must state that only gasoline purchases are allowed. Local policy will define the allowable use, frequency, and amounts; issuance procedures; circumstances for denial; and tracking and follow-up procedures. Vouchers, bus passes, or tokens cannot be exchanged for cash or used for anything other than the allowable goods or services. Systems must be in place to account for disbursed vouchers, bus passes, and tokens.

- **Non-Medical Case Management Services** provide coordination, guidance, and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services. The FDOH HIV/AIDS Section has limited the use of the non-medical case management service category to fund eligibility staff only. Staff responsible, wholly or in part, for conducting eligibility determination activities should be funded under the non-medical case management service category for the proportion of time they are engaged in such duties.
- **Outreach Services** are limited to those individuals who either do not know their HIV status or know their status but are not currently in care. When Ryan White Part B or PCN funded activities identify someone living with HIV, eligible clients should be expeditiously linked to care. Outreach services are restricted to times and places where there is a high probability that PLWH will be identified. Coordinated service delivery with local and state HIV prevention outreach programs is required to avoid duplication of effort. Outreach services must not be delivered anonymously or include activities that exclusively promote HIV prevention education.
- **Psychosocial Support Services** may not be used to provide nutritional supplements. Ryan White Part B or PCN funded pastoral counseling must be available to all eligible clients, regardless of their religious denominational affiliation. Ryan White Part B or PCN funds may not be used for social/recreational activities or to pay for a client's gym membership.
- **Referrals for Health Care and Support Services** are limited to referrals provided outside of outpatient/ambulatory health care and case management.
- **Substance Abuse Services (Residential)** are permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under Ryan White Part B or PCN funding. Ryan White Part B or PCN funds may not be used for inpatient detoxification in a hospital setting unless the detoxification facility has a separate license. Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under Ryan White Part B or PCN.

The FDOH HIV/AIDS Section must adhere to the limitations and restrictions imposed by HRSA as well as the state of Florida. In general, the more restrictive standard applies in the event of a discrepancy between federal and state requirements. Refer to the Housing Support Services Guidance at <http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/community-programs.html>, Refer to Appendix H for details regarding general categories that are unallowable expenses under Ryan White Part B, GR, and PCN. Specific limitations to allowable items can be found in the *Reference Guide for State Expenditures*, which is linked to in Appendix A.

H. Vital Status

Lead agencies and providers cannot bill for services after a client is deceased or when closing a client file due to death. Lead agencies and providers must not record a service in CAREWare

related to data entry when closing a case due to death. The following guidelines must be adhered to when closing a client in CAREWare due to death:

- Update the “Enrollment Status” to “Referred/Discharged.”
- Change the “Vital Status” to “Deceased.”
- Enter a “Date of Death.”
- Enter a “Case Closed Date.” This should match the date of death unless the client was closed out prior to death.
- Add any necessary notes in the case notes section and/or comments box.

Section 3: Contract Budget

The contract manager is required to save all lead agency budget documents on the shared drive, including the budget summary, budget narrative, and any subsequent revisions. These documents must be saved in the “Budget Documents” folder within the current contract year for Ryan White Part B and PCN funding. The file name must contain the agency name, type of budget document, and effective date; for example, “Agency XYZ Budget Summary 4.1.19” or “Agency XYZ Budget Narrative 4.1.19.” After the documents are posted to the shared drive, the contract manager is required to email the community programs coordinator, fiscal monitor, and appropriate AIMS staff.

Please note: The FDOH HIV/AIDS Section reserves the right to deny and/or revise any budget documents that do not meet FDOH and/or HRSA policy requirements.

This section provides information regarding the development of the program budget, guidelines for completing the budget summary and budget narrative, and restrictions and proper processes related to budget revisions. The service priorities specified within these guidelines should be referred to during the development of Ryan White Part B and GR PCN contract budgets.

Ryan White Part B and PCN funds for Florida’s HIV care programs can be used for the following purposes and should address these areas of responsibility:

- Coordinating and expanding existing services and identifying service gaps and barriers to care.
- Providing comprehensive outpatient essential health and support services for PLWH.
- Providing health and support services to women and youth living with HIV, including treatment measures to prevent the perinatal transmission of HIV.
- Providing services that prevent unnecessary hospitalization.

A. Budget Categories

Budget categories contained in the budget summary and budget narrative are explained in this section. There are four potential categories for the lead agency to consider when developing a budget.

The following documentation will be required for the lead agency to be paid for funded positions, regardless of the budget category:

- Invoices for fringe benefits (health, dental, life, and disability insurance; retirement; etc.). Invoices should show the provider's name and address, the period of benefit coverage, the amount of total invoice, and the amount paid for each applicable employee. Proof of payment for the corresponding fringe benefit is required.
- 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, the employee’s 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 contract. Proof of payment to the payroll company is required.

1. Administrative Costs

- a. **Provisions:** Lead agencies must ensure that administrative expenditures (inclusive of all subcontracts) do not exceed 7.5 percent 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 percent limit. For example, lead agency XYZ is awarded \$10,000. Of that amount, \$750 (7.5 percent) may be used toward 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) to some or all subcontractors. However, the administrative funds are allocated, the area's aggregate total administrative expenses must not exceed the 7.5 percent (\$750).

All indirect expenses must be considered administrative expenses subject to the maximum threshold, including expenses associated with:

- All activities associated with contract award procedures, including the development of requests for proposals, subrecipients and contract proposal review activities, negotiations, and awarding of contracts.
- Communications, such as postage costs.
- Compliance with grant conditions and audit requirements.
- Development and establishment of reimbursement and accounting systems.
- Facility security costs.
- 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 maximum threshold).
- 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.

CHD lead agencies will place all aggregate indirect costs in the "CHD ONLY" tab under the correct category level to accurately compensate counties based on Schedule C.

- b. **Positions:** The budget narrative 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.
 - a. Total annual salary.
 - b. Funding amount and percentage of total position funding.
 - c. Other funding sources, including amount and percentage of total if position is partially funded by the contract.

CHD lead agencies will place all positions in the “CHD ONLY” tab under the correct category level to accurately compensate counties based on Schedule C.

- c. **Fringe Benefits:** The following fringe benefits must be included in the budget narrative:
 1. Federal Insurance Contributions Act (FICA) – include the 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 other fringe benefits for the employee paid by the employer.

CHD lead agencies will place all aggregate indirect costs in the “CHD ONLY” tab under the correct category level to accurately compensate counties based on Schedule C.

- d. **Staffing:** If a position funded by Ryan White Part B or PCN is vacant for more than two weeks, it must be reported in writing to the contract manager. For all lead agencies anticipating filling the vacancy, an update to the budget narrative (and the “CHD ONLY” tab, if applicable) is required for the vacancy and again when the position is filled (changing the date in the file name to indicate the update). These updates must then be emailed to the community programs coordinator and the 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. Who, what, where, when, how, and why the travel is necessary must be specified.

Travel included in a contracted lead agency’s budget requires completion of the “State of Florida Authorization to Incur Travel Expense” (Form C-676C) prior to travel; the “State of Florida Voucher for Reimbursement of In-State Travel Expenses” (DH 676A) must be submitted after completion of travel. Both must be made available to the contract manager (along with the original receipts for expenses incurred during officially authorized travel, such as car rental, air transportation, parking, lodging, tolls, and fares). Refer to Appendix I for images of these two forms or request an electronic version from the contract manager.

Travel included in a CHD lead agency’s budget requires completion of a “Travel Authorization Request” (TAR) in the Statewide Travel Management System (STMS), which must be approved prior to travel. CHD lead agencies are required to submit travel expenses in the STMS (scanning and attaching the original receipts for expenses incurred during officially authorized travel, such as car rental, air transportation, parking, lodging, tolls, and fares) for reimbursement after completion of travel.

Use of Ryan White Part B and PCN funds for out-of-state travel is prohibited without prior approval by the Patient Care Program manager. Requests for out-of-state travel

must be submitted in writing to the contract manager and the Patient Care Program manager using the travel forms included in Appendix I.

2. Direct Care Costs

Core medical services are a set of essential, direct health care services provided to PLWH and are defined in Appendix E. Support services are a set of services needed to achieve medical outcomes that affect the HIV-related clinical status of PLWH and are also defined in Appendix E. The funding for support services must contribute to positive medical outcomes. Lead agencies must document in the budget narrative and in the providers' individual case notes that support services 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 used to provide core medical and support services to eligible Ryan White Part B clients (e.g., clinic, pharmacy, food bank, and any portion of a facility that provides substance abuse treatment, case management, and/or eligibility determination) is allowable as a direct care expense (and NOT an administrative cost). The allocation methodology or base for rent and utilities or interest, depreciation, and utilities must be selected appropriately per 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 percent of the total amount allocated to each relevant direct care line item (core medical or support services) may be charged as it relates to the following items:

- Core eligibility determination and re-determination and 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 ensure 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 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, as well as 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, data entry related to client-level data used to improve the quality of service delivery, and thus the health of PLWH, is allocable to CQM; client-level data entered to complete the RSR count toward the 7.5 percent administrative costs 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 funded service category.

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

1. **Service Category** – name the service; for example, “case management (non-medical).”
2. **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.
3. **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.
4. **Other Allowable Programmatic Administrative Expenses 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 Patient Care Policy Notice #2016-01. **Please note: The total of these expenses CANNOT exceed 5 percent 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.
5. **Providers/Facilities** – list all providers or facilities where services will be provided.
6. **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.
7. **Allocation Methodology** – explain how the amount allocated to this service was decided. Describe the process for priority settings and allocations.
8. **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 local planning group and other related policies or guidelines.

CHD lead agencies will place all estimated in-house costs or contracts for the budget module in the “CHD ONLY” tab under the correct category levels to accurately compensate counties based on Schedule C.

Ryan White 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 HIV programs or materials designed to promote or directly encourage intravenous drug use or sexual activity.
- Employment and employment readiness services.
- Funeral, burial, cremation, or related expenses.
- Gift cards, except approved grocery vouchers and gas cards as defined.
- 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 improvement of land or purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility.
- Syringe services distributing sterile needles or syringes for hypodermic injection of any illegal drugs.

3. CQM Costs

Lead agencies must ensure that CQM expenditures (inclusive of all subcontracts) do not exceed 5 percent 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 percent limit.

CQM activities include:

- **Capacity building** – training on and development of 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 in and contribute effectively to the delivery of HIV care.
- **CQM** – 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 for CQM 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.
 - a. Total annual salary.
 - b. Total annual fringe.
 - c. Funding amount and percentage of total position funding.
 - d. 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 percent 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 percent limit.

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

- **Capacity building** – capacity building activities aimed at increasing the availability of services to eligible PLWH through the agency's service network.
- **Needs assessment** – gathering an array of information to identify trends and common themes among PLWH.
- **Program evaluation** – structured interpretation and giving of meaning to predicted or actual impacts of proposals or results. Program evaluation looks at original objectives, what is either predicted to be or what was accomplished, and how it will be/was accomplished (e.g., assessment of service delivery patterns).

Planning and evaluation may include travel for two attendees to the Florida Comprehensive Planning Network (FCPN) meeting to represent patient care. These funded attendees should be Ryan White grantee partners or selected planning body members considered essential to the FCPN effort.

The budget narrative section for planning and evaluation 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 and fringe breakdown.
 - a. Total annual salary.
 - b. Total annual fringe.
 - c. Funding amount and percentage of total position funding.
 - d. Other funding sources, including amount and percentage of total, if position is partially funded by the contract.

B. Subcontract Budgets

All subcontracts must be prepared using these budget guidelines. Lead agencies are required to use the current budget summary and budget narrative templates provided by the FDOH HIV/AIDS Section, without any modifications, for all subcontract budgets. Refer to Appendix J for an image of the budget summary template. An electronic version can be obtained from the contract manager or community programs coordinator. A detailed budget narrative that includes all the components of the lead agency's budget narrative is required, and an electronic version can be obtained from the contract manager or community programs coordinator. During the contract review process, the allocations for administrative, direct care, CQM, and planning and evaluation costs will be compared to the prior year's allocations for significant increases, decreases, or eliminations.

C. Budget Revisions

Budget revisions to patient care contracts do not require a contract amendment. However, approval from the FDOH HIV/AIDS Section Patient Care Program is required prior to execution of most budget revisions.

- The contract manager may not approve a budget revision within the first 90 days of the funding period without prior approval in writing from the community programs coordinator, community programs supervisor, or Patient Care Program manager.

- The contract manager may not approve a budget revision within the last 30 days of the funding period without prior approval in writing from the community programs coordinator, community programs supervisor, or Patient Care Program manager.
- The contract manager may not approve a budget revision that decreases the direct care portion of the budget without prior approval in writing from the community programs coordinator, community programs supervisor, or Patient Care Program manager.
- The contract manager may not approve a budget revision that decreases core medical services without prior approval in writing from the community programs coordinator, community programs supervisor, or Patient Care Program manager.
- The contract manager may not approve budget revisions more than two per funding period, regardless of the circumstances, without prior approval in writing from the community programs coordinator, community programs supervisor, or Patient Care Program manager.

After receiving written approval from the FDOH HIV/AIDS Section Patient Care Program, in the instances cited above, the contract manager will approve or deny the budget revision. The contract manager cannot approve a revision that has received written denial from the FDOH HIV/AIDS Section Patient Care Program. The contract manager does not require prior approval for budget revisions that decrease administrative, CQM, and/or planning and evaluation costs while increasing the direct care portion of the budget. Likewise, the contract manager does not require prior approval for budget revisions that decrease support services while increasing core medical services.

The budget revision is not executed until the required budget summary template has been signed and dated by the contract manager. Lead agencies and subcontractors must report all budget revisions on the required budget summary template using the process outlined below:

- For the first budget revision in the funding period, complete the middle column, labeled "Increase/Decrease," and the right column, labeled "Revised Allocation I."
- For the second budget revision in the funding period, modify the budget summary used for the first budget revision by overwriting the left column, labeled "Original Allocation," with "Revised Allocation I"; completing the middle column, labeled "Increase/Decrease"; and changing the right column, labeled "Revised Allocation I," to "Revised Allocation II."
- Proper forecasting and projections should limit the number of budget revisions to no more than two within the funding period (one prior to the third quarter and one prior to the fourth quarter).
- If subsequent budget revisions are required to meet urgent and/or unforeseen circumstances, then the same renaming process should be carried forward. For example, if a third budget revision is required in the funding period, modify the budget summary used for the second budget revision by overwriting the left column, labeled "Revised Allocation I," with "Revised Allocation II"; completing the middle column, labeled "Increase/Decrease"; and changing the right column, labeled "Revised Allocation II," to "Revised Allocation III."

In addition to revising the required budget summary template, the budget narrative detailing the administrative, direct care, CQM, and planning and evaluation line items must be updated to reflect the current budget revision. The file name for any revised budget document must contain the agency name, type of budget document name, and date of executed budget revision. For example, a budget revision executed on October 3, 2019, by Agency XYZ would have the following file names for the revised budget summary and budget narrative: "Agency XYZ Budget Summary Rev10.3.19" and "Agency XYZ Budget Narrative Rev10.3.19." Once a budget revision

is approved by the contract manager, the contract manager is responsible for saving the revised budget summary and budget narrative in the contract folder of the shared drive. Additionally, the contact manager must email the revised budget documents to the community programs coordinator and the appropriate AIMS staff.

Please note: Any changes to the budget summary must also be reflected in the budget narrative, including the “CHD ONLY” tab (if applicable). When updating budget documents, a date must be added at the end of the file name to depict the most recent version.

D. QFR

A QFR, with details on how the administrative costs have been spent, is required. 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 during the funding period as required by FDOH and HRSA. Ryan White Part B and GR contracts shall be monitored any time after the first 120 days but before the final 90 days of the contract end date. Combined monitoring of Ryan White Part B and GR contracts is allowed. Additional on-site monitoring visits may be required, depending on the contract's relative risk, to ensure program compliance with contract requirements. FDOH Division of Administration, Bureau of Finance and Accounting, Federal Compliance and Audit Management Section, requires programs to consider risk when determining the nature, timing, and extent of monitoring. The following factors play into the determination of relative risk:

- Complexity of the services.
- Whether the contract is new or a renewal.
- Program fiscal requirements.
- Lead agency's experience and expertise.
- Lead agency's past performance.
- Risks to clients and citizens.
- Total dollar amount of the agreement.

CHD lead agencies and lead agencies with an FDOH Division of Disease Control and Health Protection (DCHP) contract manager are monitored by the community programs coordinator and fiscal monitor, whereas local contract managers monitor the remaining contracted lead agencies. The need for corrective action(s) discovered during a monitoring must be clearly noted by the contract manager, community programs coordinator, and fiscal monitor in a corrective action plan (CAP).

The CAP identifies actions that must be taken by the lead agency to address areas of noncompliance. The monitor's letter to the lead agency describing areas of noncompliance requires a response with a CAP within 30 calendar days of receipt. Any areas identified in the CAP must be sufficiently improved to meet HRSA national monitoring standards within 120 calendar days of receipt. The monitor verifies improvement through remote document review and during the lead agency's next monitoring visit. Documentation reflecting resolution of corrective actions must be reported to the contract manager, community programs coordinator, and fiscal monitor. The contract manager must save all monitoring documentation on the FDOH shared drive.

The Patient Care Universal and Programmatic Monitoring Tool and the Patient Care Fiscal and Contract Monitoring Tool templates are emailed to contract managers, HAPCs, and lead agencies. The "Ratings Based Upon" column requires verification of all provisions related to each monitoring standard either by supporting documentation or by direct observation by the contract manager, community programs coordinator, or fiscal monitor. Rating choices are "Unacceptable," "Fully Met" and "Not Applicable." A description of the supporting documentation monitoring staff reviewed is required. Additionally, monitoring staff must specify who observed what. In no instance may the rating be based upon an interview alone. Comments are required when provisions are rated "Unacceptable" or "Not Applicable" so that a reviewer outside of the FDOH HIV/AIDS Section has a thorough understanding of why this rating was selected.

Contract managers are responsible for:

- Being familiar with HRSA’s fiscal, programmatic, and universal national monitoring standards as well as the most current *Ryan White HIV/AIDS Program Part B Manual*.
 - Completing an administrative assessment for a new lead agency or when there are questions regarding the lead agency’s financial viability. A sample administrative assessment form is included as Appendix K, which can be adapted for local use.
 - Ensuring that lead agencies have sufficient infrastructure to support their contracts and meet their deliverables.
 - Monitoring the lead agency for compliance with the contract and emailing the completed monitoring report to the FDOH DCHP Contract Unit within 20 business days of the last day of the monitoring visit.
 - Notifying the HAPC, community programs coordinator, and fiscal monitor if there are concerns about lead agency viability.
 - 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 in AIMS, as listed in Section 5.
 - Saving all completed lead agency monitoring documents within 20 business days of the last day of the monitoring visit in the contract folder of the shared drive. At a minimum, the required contract monitoring documents include:
 - Letter to the lead agency.
 - Page one of FDOH form 1122.
 - Patient Care Program client file review tools.
 - Patient Care Universal and Programmatic Monitoring Tool.
 - Patient Care Fiscal and Contract Monitoring Tool.
- After posting these documents to the shared drive, the contract manager should notify via email the designated liaison in the DCHP Contract Unit as well as the community programs coordinator and fiscal monitor.
- Supporting lead agencies with technical assistance, as needed.
 - Verifying that the lead agency is registered with the Florida Department of State Division of Corporations database. The Division of Corporations is the state of Florida's official business entity index and commercial activity website.

B. Monitoring Subcontracted Providers

All subcontracted providers must be monitored annually any time after the first 120 days but before the final 90 days of the subcontract end date. Lead agencies are required to use both the Patient Care Universal and Programmatic Monitoring Tool and the Patient Care Fiscal and Contract Monitoring Tool. The “Ratings Based Upon” column requires verification of all provisions related to each monitoring standard either by supporting documentation or by direct observation by the lead agency contract manager. A description of the supporting documentation the lead agency contract manager reviewed is required. Additionally, the lead agency contract manager must specify who observed what. In no instance may the rating be based upon an interview alone. Comments are required when provisions are rated “Unacceptable” or “Not Applicable” so that a reviewer outside of the lead agency has a thorough understanding of why this rating was selected. Additional monitoring tools should be used as necessary to ensure subcontracted providers comply with the deliverables in the subcontract.

Lead agencies are responsible for:

- Assessing the financial viability of subcontractors by reviewing the organization's most recent audit or performing an administrative assessment. A sample administrative assessment form, which can be adapted for local use, is included as Appendix K.
- Being familiar with HRSA's fiscal, programmatic, and universal national monitoring standards as well as the most current *Ryan White HIV/AIDS Program Part B Manual*.
- Completing an administrative assessment for all new subcontractors or subcontractors that have received an increase in their contract amount of 25 percent or more. The administrative assessment can be performed by the lead agency or an entity engaged by the lead agency for this purpose.
- Ensuring that subcontracted providers have sufficient infrastructure to support their contracts and meet their deliverables.
- Monitoring subcontracted providers for compliance with the contract and providing all completed lead agency monitoring documents to the FDOH contract manager within 20 business days from the last day of the monitoring visit. At a minimum, the required contract monitoring documents include:
 - Letter to the subcontracted provider(s).
 - Patient Care Program client file review tools.
 - Patient Care Universal and Programmatic Monitoring Tool (for services provided).
 - Patient Care Fiscal and Contract Monitoring Tool.
- Notifying the contract manager, HAPC, community programs coordinator, and fiscal monitor if there are concerns about subcontractor viability.
- Participating in area conference calls as needed.
- Providing a list of projected monitoring dates to the contract manager, community programs coordinator, and fiscal monitor within 30 days of the start of the contract.
- Reviewing and monitoring the data subcontractors are required to enter into CAREWare and AIMS.
- Supporting subcontracted providers with technical assistance, as needed.

C. Monitoring MOA/MOU, Purchase Orders, and Other Provider Agreements

All MOA/MOU, purchase orders, and other provider agreements must be monitored annually to ensure compliance with programmatic standards any time after the first 120 days but before the final 90 days of the funding period end date. Lead agencies are required to reference the relevant programmatic standards found within the Patient Care Universal and Programmatic Monitoring Tool within a narrative report submitted to the contract manager. Lead agencies must document whether or not the provisions related to each monitoring standard for the relevant service category have been satisfied either by supporting documentation or by direct observation. A description of the supporting documentation and/or client files the lead agency reviewed is required. Additionally, the lead agency must specify who observed what.

Lead agencies are responsible for:

- Ensuring all providers have the requisite certification, licensure, and/or registration as required.

- Ensuring all services provided were allowable under the appropriate service category definition.
- Reviewing client files as required by the programmatic standards for the relevant service category.
- Reviewing program records as required by the programmatic standards for the relevant service category.
- Supporting providers with technical assistance, as needed.

D. HRSA Monitoring Standards

HRSA has designed monitoring standards to provide clear guidance to Ryan White Part B grantees and subgrantees on HRSA HIV/AIDS Bureau (HAB) expectations in terms of monitoring provider performance. The monitoring standards provide benchmarks that meet federal legislative and regulatory guidelines and represent sound practice. HRSA's fiscal, programmatic, and universal national monitoring standards have been incorporated into the Patient Care Program's monitoring tools; these tools must be used for both Ryan White Part B and GR contracts and subcontracts. It is the responsibility of lead agencies and contract managers to be familiar with these monitoring standards. Listed below are links to HRSA's Ryan White Part B national monitoring standards:

- HRSA Fiscal Monitoring Standards
hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringpartb.pdf
- HRSA Programmatic Monitoring Standards
hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA Universal Monitoring Standards
hab.hrsa.gov/manageyourgrant/files/universalmonitoringpartab.pdf
- HRSA FAQs:
hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringfaq.pdf

In the context of the HRSA monitoring standards: "grantee" refers to the HIV/AIDS Section or its designee, including an FDOH contract manager; "agreements" refers to contracts, subcontracts, memoranda of agreement, or other similar written agreements as well as Schedule C instruction letters; "contract manager" refers to either the FDOH 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 Patient Care Program contracted providers and CHDs are required to adhere to reporting requirements as defined by state and federal requirements 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, for services funded by Ryan White Part B, GR, PCN, and HOPWA, providers must use FDOH's instance of CAREWare for manual data entry or data uploads.

To assist contracted providers and CHDs in meeting their reporting requirements, as listed below in Section B. Report Submission, the HIV/AIDS Section has developed AIMS, a web-based, aggregate-level reporting system that allows primary contracted providers and CHDs to electronically report to the HIV/AIDS Section. Contact the HIV/AIDS Section Help Desk at 850-245-4744 for access to, training for, questions about, and/or help with AIMS.

Contracted providers and CHDs are expected to report aggregate data on client demographics and expenditures in AIMS and client-level data directly (manual data entry) or indirectly (data upload) in CAREWare. The HIV/AIDS Section Help Desk is responsible for assisting contracted providers and CHDs in creating and setting up domains in CAREWare for data entry.

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 both the CAREWare and AIMS user manuals should be used as guidance for reporting requirements. Appendix G lists what constitutes a unit of service for each direct care service category.

B. Report Submission

Ryan White Part B Consortia and Emerging Communities		
Report Name	Due Date*	Responsible Party
Annual Progress Report (April 1–March 31 of previous contract year)	Finalized report due in June of the reporting year; includes Final Implementation Plan. Report submitted via AIMS.	Provider
Final Expenditure and Reimbursement Report	45 days from the end of the contract end date (e.g., if the contract ends March 31, the report is due by May 15). Report submitted via AIMS.	Contract manager and provider
First Time This Year (FTTY) Report	Within 20 days of the end of each month or with the monthly invoice, whichever is earlier.	Provider

	Report submitted via AIMS.	
Monthly Expenditure and Reimbursement Report	Within 20 days of the end of each month or with the monthly invoice, whichever is earlier. Report submitted via AIMS.	Contract manager and provider
Program Terms Report (April 1–March 31 of current contract year)	Finalized report due in May of the reporting year; includes Revised Implementation Plan. Report verified and submitted via AIMS.	Provider
Provider/Subcontractor Report (April 1–March 31 of current contract year)	Identification of subcontractors is completed during budget planning in AIMS; report is generated from this data and is due in May of the reporting year. Data collected via AIMS.	Provider
RSR (January 1–December 31 of contract year)	Finalized report due in the HRSA Electronic Handbook in March; providers must submit preliminary RSR reports in the HRSA Electronic Handbook by February 15 of each reporting year.	Provider
Women, Infants, Children, and Youth (WICY) Report (April 1–March 31 of previous contract year)	Finalized report due in June of the reporting year. NOTE: Provider is <u>not</u> required to submit a report; WICY data is collected via monthly FTTY report.	Provider

***If a reporting due date falls on a weekend or holiday, the report will be due on the preceding business day.**

General Revenue Patient Care Network		
Report Name	Due Date*	Responsible Party
Final Expenditure and Reimbursement Report	45 days from the end of the contract end date (e.g., if the contract ends June 30, the report is due by August 14). Report submitted via AIMS.	Contract manager and provider
First Time This Year (FTTY) Report	Within 20 days of the end of each month or with the	Provider

	monthly invoice, whichever is earlier. Report submitted via AIMS.	
Monthly Expenditure and Reimbursement Report	Within 20 days of the end of each month or with the monthly invoice, whichever is earlier. Report submitted via AIMS.	Contract manager and provider
Provider/Subcontractor Report (July 1–June 30 of current contract year)	Identification of subcontractors is completed during budget planning in AIMS; report is generated from this data and is due in November of the reporting year. Data collected via AIMS.	Provider

***If a reporting due date falls on a weekend or holiday, the report will be due on the preceding business day.**

Appendix A: Resources

The resources listed below provide information on various aspects of HIV patient care program management and administration.

- *AIDS Information Management System User Manual*
[floridaaids.org/patient-care/ documents/AIMS 2 1 User Manual v1 0.pdf](http://floridaaids.org/patient-care/documents/AIMS_2_1_User_Manual_v1_0.pdf)
- [APA Statewide Formulary \(placeholder for link to resource\)](#)
- *CAREWare User Manual*
[floridaaids.org/patient-care/reporting/ documents/cw-manual-final.pdf](http://floridaaids.org/patient-care/reporting/documents/cw-manual-final.pdf)
- Chapter 64D-4, Florida Administrative Code (F.A.C.)
flrules.org/gateway/ChapterHome.asp?Chapter=64D-4
- Chapter 64F-16.006, F.A.C.
flrules.org/gateway/ruleno.asp?id=64F-16.006
- Checklist for the Review of an HIV-Specific Quality Management Plan
nationalqualitycenter.org/files/agm-2006-resources-2/09-quality-management-plan-review-checklist-5-16-06/
- *Florida Department of Health HIV Case Management Guidelines*
[floridaaids.org/patient-care/ documents/case-management/ documents/Case_Management_Guidelines_Complete_FINAL_6-25-19.pdf](http://floridaaids.org/patient-care/documents/case-management/documents/Case_Management_Guidelines_Complete_FINAL_6-25-19.pdf)
- Florida Department of Health HIV/AIDS Section
floridaaids.org
- *Florida HIV/AIDS Ryan White Part B Eligibility Procedures Manual*
[floridaaids.org/patient-care/ documents/eligibility-information/eligibility-manual-6-28-16-c.pdf](http://floridaaids.org/patient-care/documents/eligibility-information/eligibility-manual-6-28-16-c.pdf)
- HRSA HIV/AIDS Bureau
hab.hrsa.gov
- HRSA Monitoring Standards Guidance
hab.hrsa.gov/manageyourgrant/granteebasics.html
- HRSA Policy Notices and Program Letters
hab.hrsa.gov/manageyourgrant/policiesletters.html
- Housing Support Services Guidance
<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/community-programs.html>
- *Integrated HIV Prevention and Care Plan Guidance, Including the Statewide Coordinated Statement of Need, CY 2017-2021*
hab.hrsa.gov/manageyourgrant/hivpreventionplan062015.pdf
- *National HIV/AIDS Strategy for the United States: Updated to 2020*
hiv.gov/federal-response/national-hiv-aids-strategy/nhas-update
- *Reference Guide for State Expenditures*
myfloridacfo.com/Division/AA/Manuals/Auditing/Reference_Guide_For_State_Expenditures.pdf
- Ryan White HIV/AIDS Program (Parts A, B, C, D, and F)
hab.hrsa.gov/abouthab/aboutprogram.html

- *Ryan White HIV/AIDS Program Part B Manual*
hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/habpartbmanual2013.pdf
- *Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual*
careacttarget.org/library/ryan-white-hiv-aids-program-services-report-rsr-instruction-manual

Appendix B: FDOH HIV/AIDS Section Patient Care Administered Programs/Funding Streams

AIDS Drug Assistance Program

ADAP is the largest program funded through Ryan White Part B. ADAP is a statewide, federally funded prescription medication program for low-income PLWH. ADAP provides services for persons in need of long-term assistance (more than three months) in obtaining their HIV medication. ADAP may pay health insurance costs instead of buying medications for clients. ADAP assists with some premiums and with out-of-pocket costs for drugs on the ADAP formulary. Out-of-pocket costs can be deductibles, co-pays, or coinsurance. Those seeking ADAP services must submit an initial enrollment eligibility application and recertify into the program every six months.

For more information on Florida's ADAP, please call 850-245-4422.

General Revenue

There are 32 CHDs that receive specific GR funding to operate HIV patient care programs to improve the health of HIV patients.

GR Patient Care Networks

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

Housing Opportunities for Persons With AIDS

The **State HOPWA Program** is funded by the U.S. Department of Housing and Urban Development (HUD) to provide temporary short-term rent, mortgage, and utility (STRMU) assistance; tenant-based rental assistance (TBRA); transitional housing; permanent housing placement (PHP); supportive housing services; resource identification; and housing case management to eligible PLWH. The HIV/AIDS Section funds 11 State HOPWA Program project sponsors in Florida to provide these services.

For more information on Florida's HOPWA Program, please call 850-245-4422.

City HOPWA programs also exist. HUD provides funds directly to Florida's large metropolitan cities, with coverage areas including Miami-Dade County, Broward County, Palm Beach County, the Tampa area, the Orlando area, and the Jacksonville area. As HUD provides HOPWA funds directly to cities within these areas, they do not receive State HOPWA Program funding. Please refer to the project sponsor within each area for more information about their HOPWA program.

Ryan White Part B Consortia

The Ryan White HIV/AIDS Treatment Extension Act of 2009 (hereafter referred to as the Ryan White Program) provides the federal HIV programs (in the Public Health Service Act under Title XXVI) the 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 PLWH across the country.

The Ryan White Program is not an entitlement program, such as Medicaid or Medicare. Service availability is directly related to funding allocations. Ryan White Part B Consortia funding provides outpatient medical care, pharmaceuticals, dental services, mental health counseling, case management, and many other services to eligible individuals. FDOH contracts with fiscal lead agencies to provide these services in the designated geographic areas throughout the state. Florida's fiscal lead agencies provide administrative support to local planning groups to act in an advisory capacity to the FDOH HIV/AIDS Section for the purpose of planning and prioritizing the use of Ryan White Part B funds.

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 funding provides services very similar to those provided through Ryan White Part B Consortia funding. Ryan White Part B Emerging Communities coordinate services and planning activities with their local planning group.

Appendix C: Glossary of Acronyms and Terms

ADAP—AIDS Drug Assistance Program.

AIDS—Acquired Immune Deficiency Syndrome.

AIMS—AIDS Information Management System, a web-based, aggregate-level reporting system developed by the FDOH HIV/AIDS Section that allows primary contracted providers and CHDs to electronically report to the HIV/AIDS Section.

APA—AIDS Pharmaceutical Assistance.

CAP—Corrective Action Plan.

Cap on charges—limitation on aggregate charges imposed during the calendar year based on Ryan White HIV/AIDS Program patients' annual gross income. All fees are waived once the limit on annual aggregate charges is reached for the calendar year.

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.

DCHP—Division of Disease Control and Health Protection.

DOHP—Department of Health Policy (state).

EFA—Emergency Financial Assistance.

EIS—Early Intervention Services.

F.A.C.—Florida Administrative Code.

FAQ—Frequently Asked Question.

FDA—Food and Drug Administration.

Fee schedule—A complete list of billable services and their associated fees based on locally prevailing rates or charges.

FCPN—Florida Comprehensive Planning Network.

FDOH—Florida Department of Health.

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.

FTTY—First Time This Year.

GR—General Revenue.

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, a public health service agency that administers programs designed to increase health care for the medically underserved. This includes the Ryan White Program as well as education and training programs for health care providers and community service workers who care for PLWH. HRSA also administers programs that demonstrate how communities can organize their health care resources to develop integrated, comprehensive systems of care for PLWH.

HUD—Housing and Urban Development, the federal agency that administers the HOPWA program.

MOA—Memoranda of agreement.

MOU—Memoranda of understanding.

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 epidemic.

Part B—Part of the Ryan White HIV/AIDS Treatment Extension Act of 2009 that is administered by the state through contracts with local fiscal lead agencies in Florida's 17 geographic areas.

Part C—Early Intervention Services (EIS), the program of the Ryan White HIV/AIDS Treatment Extension Act of 2009 that funds comprehensive primary health care in an outpatient setting for PLWH.

PCN—Patient Care Network (General Revenue).

PHP—Permanent Housing Placement.

PLWH—Persons Living with HIV.

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. The Ryan White HIV/AIDS Program is the largest federal program focused exclusively on HIV care. The program is for individuals living with HIV 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.

Schedule of Charges—Fees imposed on a patient for services based on the patient's annual gross income. A schedule of charges may be a flat rate.

Service provider—Any entity other than the lead agency/project sponsor that provides a service (e.g. subcontracted transportation or case management provider).

STMS—Statewide Travel Management System.

STRMU—Short-Term Rent, Mortgage, and Utility assistance.

TAR—Travel Authorization Request.

TBRA—Tenant-Based Rental Assistance.

USC—United States Code (federal).

VA—Veterans Affairs.

WICY—Women, Infants, Children, and Youth.

Appendix D: FDOH, HIV/AIDS Section, Client Complaint, Grievance, and Appeal Procedures

Introduction

The following procedures apply to programs operated under the auspices of the HIV/AIDS Section, including, but not limited to, Ryan White Part B, HOPWA, and patient care general revenue funded services. 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, at a minimum, contain the following core elements:

- 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. This includes posting information in a prominent place about clients' right to file a grievance or appeal and providing written notices that include this information in other languages to meet the needs of clients with limited English proficiency.
- Requirements for staff training by local agency staff on grievance and appeal procedures.
- Specific timeframes for resolving complaints, grievances, and appeals (see below).
- Procedures for obtaining a 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 (e.g. subcontracted transportation or case management provider).

Complaint Procedures

Providers and clients are encouraged to resolve complaints informally at the lowest organizational level possible before initiating formal grievance or appeal procedures. Complaints, whether received by a service provider, project sponsor, or lead agency, should be acknowledged within two business days.

- If the complaint is resolved to the satisfaction of the client within 10 business days, no further action is needed.
- If the complaint cannot be resolved to the client's satisfaction within 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.

Grievances and Appeals

Lead agencies/project sponsors and service providers must ensure that prospective clients are informed of grievance and appeal policies and procedures at their first meeting with a case manager. 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 their needs, 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 a specific staff position or positions that a client may contact for assistance in initiating the process. Contact information must also be provided 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 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 provider 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 business days of receipt.
- The lead agency/project sponsor is responsible for collecting all pertinent facts about the grievance from both parties.
- The individual(s) conducting the final review of a grievance must not have been 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 60 business 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 their area's HAPC and designated community programs coordinator/state HOPWA housing coordinator within five business days to seek a resolution.

The HAPC and community programs coordinator/state HOPWA housing coordinator will review the grievance and issue a written resolution to the lead agency/project sponsor within 10 business days.

Appeal Procedures

Complaints about an action, such as a denial of services, that are not resolved to the client's satisfaction within 10 business days will become an appeal and should be sent to the lead agency/project sponsor for resolution. The service provider 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 enter the appeal into the grievance and appeal log and send a written acknowledgment to the client within five business days of receipt.
- The lead agency/project sponsor is responsible for collecting all pertinent facts about the appeal from both parties.
- The individual(s) conducting the final review of an appeal must not have been 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 60 business 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.
- If the appeal is not settled to the client's satisfaction, the lead agency/project sponsor must notify their area's HAPC and designated community programs coordinator/state HOPWA housing coordinator for the area within five business days to seek a resolution.

The HAPC and community programs coordinator/state HOPWA housing coordinator will review the appeal and issue a written resolution to the lead agency/project sponsor within 10 business days.

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 amount of time approved during their initial assessment for meeting program requirements. Clients will not receive HOPWA services more than 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 for review and approval.

- 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 fabrication, misrepresentation, impersonation, and other false actions that affect a determination of eligibility to receive services. Threats of violence include verbal and non-verbal actions that threaten the safety of the client, other clients, staff, and landlords or neighbors of clients receiving HOPWA services.
- A client terminated from the program due to criminal behavior or activity may be readmitted into the program upon submission of court documents demonstrating that the

client was acquitted of all charges related to the incident that led to termination. Compelling evidence of changes in circumstances (e.g., completion of probation) and client behavior may also factor into a client's readmission into the program. However, readmission shall be contingent upon availability of program funds and the client's program eligibility at the time of a request for readmission.

- Notice of dismissal must be provided in writing to the client within five 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.
- A 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.

Please note: This document shall not supersede state or federal regulations.

Appendix E: Allowable Service Definitions

Core Medical Services

Core medical services are a set of essential, direct health care services provided to PLWH.

APA

APA provides medication assistance when ADAP has a restricted formulary, waiting list, and/or restricted financial eligibility criteria. Lead agencies funding the APA service category must establish the following:

- Uniform benefits for all enrolled clients throughout the service area.
- A recordkeeping system for distributed medications.
- An APA advisory board.
- A drug formulary approved by the local advisory committee/board.
- A drug distribution system.
- A client enrollment and eligibility determination process that includes screening for ADAP and APA eligibility with rescreening at least every six months.
- Coordination with Florida's Ryan White Part B ADAP. A statement of need should specify the restrictions of Florida's ADAP and the need for APA services at the local level.
- Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program.

EIS

EIS must be provided as a combination of services rather than stand-alone testing, referral, linkage, or outreach services. Except when prevention dollars within the area are sufficient to fully fund testing efforts, lead agencies funding the EIS service category must include the following components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV.
 - Lead agencies must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts.
 - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources.
- Referral services to improve HIV care and treatment services at key points of entry.
- Access and linkage to HIV care and treatment services.
- Outreach services and health education/risk-reduction services limited to those related to a client's HIV diagnosis.

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

ADAP may pay health insurance costs instead of buying medications for clients. ADAP assists with some premiums and with out-of-pocket costs for drugs on the ADAP formulary. Out-of-pocket costs can be deductibles, co-pays, or coinsurance. Health insurance assistance funded through ADAP is part of ADAP, not a separate program. ADAP cannot pay out-of-pocket costs for any service except pharmacy costs, nor can ADAP pay for stand-alone dental insurance. However, **health insurance premium and cost sharing assistance** may be able to help with those costs. Health insurance premium and cost sharing assistance provides financial aid to help persons maintain continuity of health insurance or receive medical and pharmacy benefits under a health care coverage program. This service category *may* also include premium assistance for stand-alone dental insurance if certain criteria are met (see below). The service provision consists of one or more of the following:

- Paying health insurance premiums to provide comprehensive HIV outpatient/ambulatory health services and pharmacy benefits that provide a full range of HIV medications.
- Paying stand-alone dental insurance premiums to provide comprehensive oral health care services.
- Paying cost sharing on behalf of the client.

To use HIV Patient Care Program funds for health insurance premium assistance (not stand-alone dental insurance assistance), the lead agency must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that, at a minimum, includes at least one U.S. FDA approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. HHS Clinical Guidelines for the Treatment of HIV as well as appropriate HIV outpatient/ambulatory health services.
- Paying for the health care coverage (including all other sources of premium and cost sharing assistance) is more cost effective than paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services.

To use HIV Patient Care Program funds for stand-alone dental insurance premium assistance, the lead agency must assess and compare the aggregate cost of paying for the stand-alone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing stand-alone dental insurance is cost effective in the aggregate.

Home and Community-Based Health Services

Home and community-based health services are provided in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services.
- Day treatment or other partial hospitalization services.
- Durable medical equipment.
- Home health aide services and personal care services in the home.

Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services and are not an allowable use of HIV Patient Care Program funds.

Home Health Care

Home health care is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. The provision of home health care is limited to clients that are homebound, as defined by Centers for Medicare and Medicaid Services. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities. Activities provided under home health care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g., intravenous and aerosolized treatment, parenteral feeding).
- Preventive and specialty care.
- Wound care.
- Routine diagnostics testing.
- Other medical therapies.

Medical Case Management, Including Treatment Adherence Services

Medical case management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical case management includes all types of case management encounters (e.g., face-to-face, over-the-phone).

Key activities include:

- Comprehensive assessment of service needs.
- Development of a comprehensive, individualized care plan.
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care.
- Continuous client monitoring to assess the efficacy of the care plan.
- Re-evaluation of the care plan at least every six months, with adaptation as necessary.
- Ongoing assessment of the client's and the client's key family members' needs and personal support systems.
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments and to ensure an understanding of the importance of compliance with medical appointments for monitoring.
- Client-specific advocacy and/or review of service use.

In addition to providing the medically oriented activities above, medical case management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, pharmaceutical manufacturers' patient assistance programs, other state or local health care and supportive services, and insurance plans through the Health Insurance Marketplace).

Effective October 1, 2019, the HIV/AIDS Section requires that **all** case management services be funded under the medical case management service category.

Medical Nutrition Therapy

Medical nutrition therapy services must be pursuant to a medical provider's referral and based on a nutritional plan developed by a registered dietitian or other licensed nutrition professional. A prescription and plan of care or chart note from the medical provider can be substituted in cases where a dietician or nutrition professional is not reasonably accessible. Medical nutrition therapy includes:

- Nutrition assessment and screening.
- Dietary/nutritional evaluation.
- Food and/or nutritional supplements per medical provider's recommendation.
- Nutrition education and/or counseling.

These activities can be provided in individual and/or group settings and outside of HIV outpatient/ambulatory health services.

Mental Health Services (Outpatient)

Mental health services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, 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.

Oral Health Care

Oral health care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Outpatient/Ambulatory Health Services

Outpatient/ambulatory health services provide diagnostic and therapeutic activities directly to a client by a licensed health care provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, mobile vans, and urgent care facilities for HIV-related visits. Telehealth services may also be considered outpatient medical care.

Allowable activities include:

- Medical history taking.
- Physical examination.
- Diagnostic testing (including HIV confirmatory and viral load testing) and laboratory testing.
- Treatment and management of physical and behavioral health conditions.
- Behavioral risk assessment, subsequent counseling, and referral. (Behavioral risk assessment and/or counseling provided outside an outpatient/ambulatory health service visit is considered a mental health service.)
- Preventive care and screening.
- Pediatric developmental assessment.

- Prescription and management of medication therapy.
- Treatment adherence.
- Education and counseling on health and prevention issues.
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology.

Substance Abuse Outpatient Care

Substance abuse outpatient care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under the substance abuse outpatient care service category include:

- Screening
- Assessment
- Diagnosis
- Treatment, including:
 - Pre-treatment/recovery readiness programs
 - Harm reduction
 - Behavioral health counseling
 - Outpatient drug-free treatment and counseling
 - Medication assisted therapy
 - Neuropsychiatric pharmaceuticals
 - Relapse prevention

Support Services

EFA

EFA provides limited one-time or short-term payments to assist clients with an urgent need for essential items or services necessary to improve health outcomes, including utilities, housing, food (groceries and food vouchers), transportation, and medication not covered by ADAP or the APA service category. Additionally, the EFA service category may be used to provide limited one-time or short-term payments to assist clients with an urgent need to pay for allowable costs required to improve health outcomes, which are associated with other eligible/allowable service categories listed in this appendix. EFA *must* occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are not permitted.

It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of funds to the EFA service category will be as the payer of last resort and for limited amounts, uses, and periods of time. EFA funds used to pay for otherwise allowable services on a short-term basis must be accounted for under the EFA service category. Continuous provision of an allowable service to a client must not be funded under the EFA service category.

Food Bank/Home Delivered Meals

Food bank/home delivered meals is the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to:

- Personal hygiene products.
- Household cleaning supplies.
- Water filtration/purification systems in communities where issues of water safety exist.

Health Education/Risk Reduction

Health education/risk reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Health education/risk-reduction services cannot be delivered anonymously.

Topics covered may include:

- Risk-reduction strategies to reduce transmission, such as PrEP for clients' partners and treatment as prevention.
- Health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid, and Medicare).
- Health literacy.
- Treatment adherence.

Housing

Housing should only be used as a last resort if a client is not qualified for Florida's State HOPWA Program and should not supplant HOPWA. Transferring the client from one HIV Patient Care Program funding source (such as HOPWA) to another (such as Ryan White Part B and/or general revenue) is not a substitute for assisting the client towards financial independence and self-sufficiency.

Allowable housing services include housing referral services and transitional, short-term, or emergency housing assistance. The housing service category should be used to cover transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment that extends beyond a one-time payment and when there is a need for additional housing services. Clients receiving housing services must have their housing needs assessed annually and an individualized written housing plan of care developed monthly to determine if there is a need for new or additional housing services and to guide the client's linkage to permanent housing. The housing service category can be used for clients that are on a waitlist for HOPWA TBRA as funding allows.

Housing activities also include housing-related referral services (and fees associated with these services), including housing assessment, search, placement, and advocacy services, which must be provided by case managers or other professionals who possess a comprehensive knowledge of local, state, and federal housing programs and how to access them.

Linguistic Services

Linguistic services include interpretation and translation activities (both oral and written) to clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the health care provider and the client. These services are to be provided when they are necessary to facilitate communication between the provider and client and/or support delivery of HIV Patient Care Program eligible services. Linguistic services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services.

Medical Transportation

Medical transportation is the provision of nonemergency transportation that enables a client to access or be retained in core medical and support services. Medical transportation may be provided through:

- Contracts with providers of transportation services.
- Mileage reimbursements (through a non-cash system) that enable clients to travel to needed medical or other support services. Mileage reimbursements should not in any case exceed the established rates for state programs.
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle.
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed).
- Gas cards issued specifically for an identified need and controlled and monitored according to local policy, which defines and limits their use, in circumstances where public and other transportation options are not available.
- Voucher or token systems.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients.
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle.
- Any other costs associated with a privately-owned vehicle, such as lease or loan payments and insurance, license, or registration fees.

Non-Medical Case Management Services

Effective October 1, 2019, the HIV/AIDS Section limits the use of the non-medical case management service category to fund eligibility specialists only. All eligibility staff should be funded exclusively under non-medical case management. For further clarification and definitions, refer to the *Florida HIV/AIDS Ryan White Part B Eligibility Procedures Manual* at floridahealth.gov/diseases-and-conditions/aids/patient-care/documents/eligibility-information/eligibility-manual-6-28-16-c.pdf.

Outreach Services

Outreach services provides the following activities:

- Identification of people who do not know their HIV status.

- Linkage or re-engagement of PLWH into HIV Patient Care Program services, including provision of information about health care coverage options.

Outreach services must:

- Use data to target populations and places that have a high probability of reaching PLWH who:
 - Have never been tested and are undiagnosed.
 - Have been diagnosed as HIV positive but have not received their test results.
 - Know their HIV-positive status but are not in medical care.
- Be conducted at times and in places where there is a high probability that PLWH will be identified.
- Be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, and TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HIV Patient Care Program services. Ultimately, HIV-negative people may receive outreach services and should be referred to risk-reduction activities. When these activities identify someone living with HIV, they should be linked to HIV Patient Care Program services.

Outreach services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care. Outreach services must not include outreach activities that exclusively promote HIV prevention education. Lead agencies and subcontractors may use outreach services funds for HIV testing when HIV Patient Care Program resources are available and where the testing would not supplant other existing funding.

Psychosocial Support Services

Psychosocial support services provide group or individual support and counseling to assist clients with addressing behavioral and physical health concerns. Psychosocial support service activities may include:

- Bereavement counseling.
- Child abuse and neglect counseling.
- HIV support groups.
- Nutrition counseling provided by a non-registered dietitian.
- Pastoral care/counseling services if available to all eligible clients regardless of their religious denominational affiliations.

Referral for Health Care and Support Services

Referral for health care and support services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist clients with obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, pharmaceutical manufacturers' patient assistance programs, and other state or local health care and supportive services or Health Insurance Marketplace plans).

Substance Abuse Services (Residential)

Substance abuse services (residential) are provided in a residential setting for the screening, assessment, diagnosis, and treatment of substance use disorders. Activities provided under the substance abuse services (residential) service category include:

- Pre-treatment/recovery readiness programs.
- Harm reduction.
- Behavioral health counseling.
- Medication assisted therapy.
- Neuropsychiatric pharmaceuticals.
- Relapse prevention.
- Detoxification, if offered in a separate licensed residential setting (including a separately licensed detoxification facility within an inpatient medical or psychiatric hospital).

Substance abuse services (residential) are permitted only when the client has received a written referral from their clinical provider as part of a substance use disorder treatment program funded under the HIV Patient Care Program. Acupuncture therapy may be an allowable cost under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the HIV Patient Care Program. HIV Patient Care Program funds may not be used for inpatient detoxification in a hospital setting unless the detoxification facility has a separate license.

Appendix F: 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, which is available at uscode.house.gov/view.xhtml?hl=false&edition=prelim&req=granuleid%3AUSC-prelim-title42-section300ff-64&f=treesort&fq=true&num=0&saved=%7CaW1wb3NpdGlvb2VzZ2Vz%7CdHJIZXNvcnQ%3D%7CdHJ1ZQ%3D%3D%7C164%7Ctrue%7Cprelim.)

Requirements regarding imposition of charges for services

(1) In general

The Grantee agrees to the following for the imposition of charges for services:

A. in the case of individuals with an income $\leq 100\%$ of the FPL, the applicant will not impose a \$1 flat-fee charge per unit of service on any such individual for the provision of early intervention or primary care services under the grant;

B. in the case of individuals with an income $> 100\%$ of the FPL, the applicant-

- i. will impose a \$1 flat-fee charge on each such individual for the provision of such services; and
- ii. will impose the \$1 flat-fee 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 the applicant for the grant agrees that-

A. in the case of individuals with an income $> 100\%$ of the FPL but $< 200\%$ of the FPL, the applicant will **not**, for any **calendar year**, impose charges in an amount $> 5\%$ of the annual gross income of the individual involved;

B. in the case of individuals with an income $> 200\%$ of the FPL but $< 300\%$ of the FPL, the applicant will **not**, for any **calendar year**, impose charges in an amount $> 7\%$ of the annual gross income of the individual involved; and

C. in the case of individuals with an income $> 300\%$ of the FPL, the applicant will **not**, for any **calendar year**, impose charges in an amount $> 10\%$ of the annual gross income of the individual involved.

(3) Assessment of charge

With respect to compliance a grantee under this part may, in the case of individuals subject to a charge for purposes of assessing the amount of the charge in the discretion of the grantee, including imposing only a nominal charge for the provision of services, subject to the provisions of such paragraph regarding public schedules regarding limitations on the maximum amount of charges; and 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 Grantee agrees that the limitations 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.

(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 G: Units of Service Definitions

SERVICE CATEGORY	UNITS OF SERVICE
CORE MEDICAL SERVICES	
AIDS Pharmaceutical Assistance (Local)	1 prescription for up to 30 days of medications ¹
Early Intervention Services (EIS)	1 testing service and/or referral and/or linkage and/or outreach
Health Insurance Premium/Cost Sharing Assistance	1 premium and/or deductible and/or co-payment ²
Home and Community Based Services	1 rehabilitation service and/or piece of durable medical equipment and/or home health aide service and/or personal care service in the home
Home Health Care	1 visit ³
Medical Case Management (Including Treatment Adherence)	1 medical case manager encounter per client per day ⁴
Medical Nutrition Therapy	1 visit and/or 1 case of supplement ⁵
Mental Health Services – Outpatient	1 visit
Oral Health Care	1 visit
Outpatient/Ambulatory Health Services	1 visit and/or each lab test and/or draw fee
Substance Abuse Services – Outpatient	1 visit
SUPPORT SERVICES	
Emergency Financial Assistance	1 assistance voucher and/or payment (rent or utilities) and/or prescription (30 days or less)
Food Bank/Home Delivered Meals	1 bag/box of food and/or grocery store voucher ⁶
Health Education/Risk Reduction	1 visit
Housing	1 month rent and/or utility assistance and/or assessment
Linguistic Services	1 translation service
Medical Transportation Services	1 one-way trip transport and/or medical transportation voucher per day for bus, taxi, or van ⁷
Non-Medical Case Management Services	1 non-medical case manager encounter per client per day ⁴
Outreach Services	1 visit
Psychosocial Support Services	1 individual or group session
Referral for Health Care/Supportive Services	1 referral for health care/supportive services encounter per client per day ⁴
Substance Abuse Services – Residential	1 day

NOTE: All service categories that are defined as one visit include telehealth in the definition of visit.

¹ The unit of service is one prescription for up to 30 days of medication. A prescription written for less than 30 days should be rounded up to the next whole number for the units of service. 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, rounded to the next whole number. For example, a prescription is

written for 90 days. The units of service are 90 divided by 30, which equals three units of service. If a prescription is written for 40 days, the units of service are 40 divided by 30 (1.3) rounded up, for two units of service.

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

³ The unit of service is one visit by a health care professional to a client's home for:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, parenteral feeding). 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 two units of service. If a different medical professional visits the same client on the same day as the nurse, this is counted as three units of service. If a health care provider administers IV therapy and stays for the duration, this is counted as one unit.
- Preventive and specialty care.
- Wound care – a unit is one hour plus the cost of supplies.
- Routine diagnostics testing.
- Other medical therapies.

⁴ 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.

⁵ The unit of service is one visit to a licensed, registered dietician outside of a primary care visit and/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.

⁶ As long as the total cost does not exceed \$35.00 per client per month, a unit of service will be one bag/box of food and/or one voucher for the purchase of groceries.

⁷ The unit of service is a one-way 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. A monthly bus pass is 30 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 would count as two units of service.

Appendix H: Prohibited Expenditures in the Reference Guide for State Expenditures

Per Rule 69I-40.103, F.A.C., expenditures from state funds for items listed below are prohibited unless “expressly provided by law”:

- Congratulatory telegrams.
- Flowers and/or telegraphic condolences.
- Presentment of plaques for outstanding service.
- Entertainment for visiting dignitaries.
- Refreshments such as coffee and doughnuts.
- Decorative items (globes, statues, potted plants, picture frames, etc).
- Greeting cards: Per s. 286.27, F.S., use of state funds for greeting cards is prohibited.

An expenditure of state funds must be authorized by law, and the expenditure must meet the intent and spirit of the law authorizing the payment. When purchasing items used generally for the personal convenience of employees that are not apparently necessary in order for an agency to carry out its statutory duties (example: portable heaters, fans, refrigerators, microwaves, clocks for private offices, coffee pots and supplies, etc.) justification or perquisite approval must be provided. State funds cannot be expended to satisfy the personal preference of employees (example: an agency may not purchase more expensive office furniture or equipment than is necessary to perform its official duties because the employee prefers a more expensive item).

Each voucher must contain documentation that shows the legal authority for the requested payment if the authority is not obvious from the face of the voucher.

Appendix J: Budget Summary Template

BUDGET SUMMARY

Organization Name: _____

For Contract Period: _____

A. ADMINISTRATIVE COSTS:

(7.5% cap on Administrative costs inclusive of subcontracts)

	<u>Original Allocation</u>	<u>Increase/Decrease</u>	<u>Revised Allocation</u>
Administration Subtotal:	\$ _____	\$ _____	\$ _____

B. CORE MEDICAL AND SUPPORT SERVICES COSTS:

Core Medical Services:

	<u>Original Allocation</u>	<u>Increase/Decrease</u>	<u>Revised Allocation</u>
a. AIDS Pharmaceutical Assistance	\$ _____	\$ _____	\$ _____
b. Early Intervention Services	\$ _____	\$ _____	\$ _____
c. Health Insurance Premium/Cost Sharing	\$ _____	\$ _____	\$ _____
d. Home and Community -Based Services	\$ _____	\$ _____	\$ _____
e. Home Health Care	\$ _____	\$ _____	\$ _____
f. Medical Case Management (including treatment adherence)	\$ _____	\$ _____	\$ _____
g. Medical Nutrition Therapy	\$ _____	\$ _____	\$ _____
h. Mental Health Services - Outpatient	\$ _____	\$ _____	\$ _____
i. Oral Health Care	\$ _____	\$ _____	\$ _____
j. Outpatient Ambulatory Health Service	\$ _____	\$ _____	\$ _____
k. Substance Abuse Services - Outpatient	\$ _____	\$ _____	\$ _____

Support Services:

l. Emergency Financial Assistance	\$ _____	\$ _____	\$ _____
m. Food Bank/Home Delivered Meals	\$ _____	\$ _____	\$ _____
n. Health Education/Risk Reduction	\$ _____	\$ _____	\$ _____
o. Housing	\$ _____	\$ _____	\$ _____
p. Linguistic Services	\$ _____	\$ _____	\$ _____
q. Medical Transportation Services	\$ _____	\$ _____	\$ _____
r. Non-Medical Case Management Services	\$ _____	\$ _____	\$ _____
s. Outreach Services	\$ _____	\$ _____	\$ _____
t. Psychosocial Support Services	\$ _____	\$ _____	\$ _____
u. Referral for Health Care/Supportive Services	\$ _____	\$ _____	\$ _____
v. Substance Abuse Services - Residential	\$ _____	\$ _____	\$ _____
Core Medical and Support Services Subtotal	\$ 0	\$ 0	\$ 0

C. CLINICAL QUALITY MANAGEMENT

	<u>Original Allocation</u>	<u>Increase/Decrease</u>	<u>Revised Allocation</u>
Clinical Quality Management Subtotal:	\$ _____	\$ _____	\$ _____

(5% cap on CQM costs inclusive of subcontracts)

D. PLANNING AND EVALUATION

(2.5% cap on Planning and Evaluation costs inclusive of subcontracts)

	<u>Original Allocation</u>	<u>Increase/Decrease</u>	<u>Revised Allocation</u>
Planning and Evaluation Subtotal:	\$ _____	\$ _____	\$ _____

GRAND TOTAL A, B, C & D	\$ 0	\$ 0	\$ 0
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Provider Signature

Date

Contract Manager Signature

Date

Effective date 4/1/2019 (earlier Versions Obsolete)

