

Patient Care Contract Administrative Guidelines

What's



in July 2011

- It is the responsibility of the agency that determines a client's eligibility to ensure that this process is done correctly. If it is later found that a client was erroneously determined eligible, the determining agency will be liable for the cost of services provided to that client. Additionally, contract managers that perform eligibility file reviews must determine the rate of error (percentage of clients that were incorrectly determined eligible) for each agency. Agencies that have an error rate above 5 percent will have the percentage of the error deducted from their eligibility allocation.

Given the potential liability to an agency for an incorrect eligibility determination, eligibility workers' supervisors must implement an aggressive eligibility file review process. A sample Eligibility File Review Form is included as Appendix I. (Section 2, page 1)

- Advances can be requested for Patient Care Network contracts only. Advances for Part B contracts are not allowed without special permission from HRSA and only for one month. (Section 2, page 1)

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

The Department of Health's Bureau Finance and Accounting recognizes that there are legitimate instances where, due to the type of services rendered, the provider will not be able to determine exactly how much will be expended and may run over a line item amount. In those cases, if prior notice is given to Finance and Accounting, Disbursements will work with the program office, contract manager and provider to accept a retroactive budget revision. This is not a universal practice and exceptions will only be made in special cases. (Section 3, page 10)

- All lead agencies must be monitored once a year. The contract monitoring must be completed after the receipt of the provider's first Quarterly Financial Report (due 30 days after the end of the first quarter) but no later than 135 days after the start of the contract. Additional monitorings may be conducted as needed to ensure programs are in compliance with contract requirements.
- HRSA has designed standards to provide clear guidance to Ryan White Part B grantees and providers about HRSA/HAB expectations in terms of monitoring provider performance. The standards provide benchmarks that meet both federal legislative and regulatory guidelines and represent sound practice. The standards assume that a direct service provider can be a lead agency that administers the program or a subcontracted provider. The standards are separated into three categories (universal, fiscal and programmatic) and are contained in Section 4 of the Administrative Guidelines. (Section 4, beginning on page 2)