West Central Florida Ryan White Care Council

Assessment of the Administrative Mechanism
Part A
2012-2013

Prepared by the Health Council of East Central
under contract by The Health Councils, Inc.

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Executive Summary

The Ryan White HIV/AIDS Program provides care for those individuals living with HIV/AIDS who have no health insurance (public or private), have insufficient health care coverage, or lack financial resources to obtain the care they need for their HIV disease. As such, the Ryan White HIV/AIDS Program fills gaps in care as the "payer of last resort." The original legislation was first enacted in 1990 as the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act and has been reauthorized four times since. The Ryan White HIV/AIDS Treatment Extension Act was reauthorized in 2009.

The Ryan White Act funds core health services and support services. Part A and Part B of the Ryan White Act provide funding for services in Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas and Polk Counties. The West Central Florida Ryan White Care Council (herein referred to as the Care Council) is a planning body that assesses needs, conducts planning, allocates resources and evaluates HIV/AIDS services in the eight county Total Service Area (TSA). Services for Part A are administered by the Ryan White Program, Hillsborough County Family & Aging Services Department (herein referred to as the Grantee Office). Services for Part B had also been administered by the Grantee Office, however, administration was transferred to the Florida Department of Health in Pinellas County during fiscal year 2012-13.

An Assessment of the Administrative Mechanism (AAM) is an evaluation of the administrative processes conducted by the Grantee Office and ensures that services are being funded as indicated by the Care Council priorities and reimbursed within a timely manner to providers. The administrative assessment reviews the Request for Application (RFA) process, contracting and contract modifications, provider reimbursement and adherence to the Care Council priorities. This AAM covers services provided under Part A and the administration by the Hillsborough County Grantee Office. The following details the major findings and recommendations of the AAM for fiscal year 2012-2013 (FY 12-13).

Results of Provider Survey

The provider survey questions were revised by the Resource Prioritization and Allocation Recommendations Committee (RPARC) and sent to a total of thirteen providers via email in July 2013. The survey was web-based and respondents had until July 30, 2013 to respond. Ten providers responded, for a response rate of 76.9 percent. In every category and question, there was an increase in the satisfaction rates over the prior year. The following summarizes the responses.

Contracts

- Overall, 100 percent of providers agreed that their contract was negotiated in a timely and fair process (10 out of 10 respondents), that their contracts were executed in a timely and efficient manner (9 out of 9 respondents), and that their contract amendments were executed in a timely and efficient manner (9 out of 9 respondents). This is an improvement to the prior year, where between 79 percent and 87 percent agreed.

Reimbursement

- Overall, 100 percent of providers (8 out of 8) agreed that the majority of their payments from Hillsborough County Government were processed within 45 calendar days. This is a large improvement from last year, when only 50 percent agreed.

Expenditures

- Overall, 100 percent of providers (7 out of 7; 3 left the question blank or marked Does Not Apply) agreed that the Grantee Office contacted their agency to review utilization and expenditure data if spending was not on target.
- Overall, 87.5 percent of providers (7 out of 8) agreed that the Grantee Office informed their agency of the reallocation processes and requirements of their spending plan in order to make necessary adjustments during the year.
- Both of these are up from the prior year (69.2 percent and 78.5 percent, respectively.)

Technical Assistance

- Of those responding, 85.7 percent of providers (6 out of 7, with 3 responding Does Not Apply or blank) agreed that they received technical assistance from the Grantee Office staff for completion of invoices, reports and other requirements as needed. This is an improvement, up from 71.3 percent last year.

Communication with Grantee Office

- Overall, 100 percent of providers (9 out of 9) agreed that the Grantee Office staff provided their agency a clear explanation of Ryan White Program reporting requirements, compared with 87.4 percent last year.
- Overall, 88.9 percent of providers (8 out of 9) agreed that the Grantee Office kept their agency well informed of HRSA policies, procedures and updates that impact Ryan White Program providers. This is up slightly, from 81.2 percent.
- Overall, 87.5 percent of providers (7 out of 8) agreed that the Grantee Office kept their agency well informed of Care Council directives that impact Ryan White Program providers, compared with 81.2 percent last year.
- All providers (100 percent, 9 out of 9 respondents) agreed that the Grantee Office Staff is courteous and respectful. This is up from 81.2 percent in the prior year.
- All providers (100 percent, 9 out of 9 respondents) agreed that the Grantee Office staff responded promptly and adequately to inquiries, requests and problem-solving needs from their agency. This is up from 74.9 percent last year.

Results of Care Council Member Survey

The Care Council member survey questions were reviewed by the Resource Prioritization and Allocation Recommendations Committee (RPARC). The survey announcement was sent via email in July 2013 with a link to the web-based survey. Respondents were asked to respond by July 30, 2013. Seventeen Care Council members out of twenty-four responded, generating a response rate of 70.8 percent (compared to a rate of 67.9 percent in the previous year).

In the prior year, 100.0 percent of Care Council members agreed or strongly agreed with all questions. This year's respondents were also very satisfied, but not entirely unanimous. Below is the summary of their responses.

Allocations and Reallocations

- Overall, 100 percent of Care Council members (16 out of 16 respondents) agreed that the Grantee Office follows the Care Council's service priorities, resource allocations and reallocations. This is up from 89.5 percent last year.

Expenditures

- Overall, 100 percent of Care Council members (17 out of 17 respondents) agreed that the Grantee Office reports expenditure data to the Care Council on a quarterly basis.

Communication with Grantee Office

- Overall, 100 percent of Care Council members (16 out of 16 respondents) agreed that Grantee Office staff respond promptly and adequately to questions (regarding resource allocation, reallocation and expenditures).
- Overall, 94.1 percent of Care Council members (16 out of 17 respondents) agreed that the Grantee Office staff clearly communicate to the Care Council about the reallocation process.
- Overall, 100 percent of Care Council members (17 out of 17) agreed that the Grantee Office staff keeps the Care Council well informed of HRSA and Florida Department of Health policies, procedures and updates that impact the Ryan White Program.

Administration

- Overall, 94.1 percent of the Care Council members (16 out of 17 respondents) agreed that the Grantee Office effectively administers grant funds.

Procurement/Request for Application (RFA) Process

There were two RFAs issued during the 2012 calendar year. From the initial issuance of the RFA to the Board of County Commissions approval, the time elapsed was 65 days for the first one and 86 days for the second one. This is down from 160 days in 2011, a significant time difference. In the provider survey, 100 percent of providers agreed that their contract was negotiated in a timely and fair process, and that contracts were executed in a timely and efficient manner. Interviews with providers confirmed their satisfaction, with respondents saying the RFA process was consistent, predictable, fair, and efficient.

Adherence to Care Council Priorities

The Care Council has an established "Service Caps/Limits" document that is reviewed annually by the Care Council and revised as needed. The approved June 2011 version established the "Service Caps/Limits" document as a separate document from the previous "Minimum Standards of Care and Services Caps/Limits" document. Service categories setting caps/limits or exclusions to the eligibility criteria included: food bank/nutritional supplements, health insurance, oral health, primary care, treatment adherence, medical case management and case management (non-medical). The current version was approved in February 2013. All responding Care Council members agreed that the Grantee Office follows the Care Council's service priorities.

Care Council Allocations and Reallocations

The Care Council and Grantee generally maintained allocations and expenditures close to the original allocation percentages. However, this year had slightly higher variances than in prior years. Underspending in the categories of Pharmaceutical Assistance, Non-Medical Case Management, and Grantee Administration and Support occurred, and for the most part these funds were reallocated to other categories. The exception was in Grantee Admin funds, where a budget oversight caused funds to be placed into the wrong area and therefore roughly $150,000 could not be spent.

Of the Care Council survey respondents, all (100%) agreed that the Grantee Office staff follows the Care Council's allocations and reallocations, and promptly and adequately responds to questions about allocation, reallocation and expenditures. In addition, 94.1 percent felt the staff clearly communicates about the reallocation process

Contracts and Contract Modifications

For the FY 12-13 Part A and MAI budget, initial allocations were approved in September 2011 so that procurement and contracting could proceed. The contract renewals and extensions were approved by the Board of County Commissioners on February 22, 2012, which is 6 days prior to the start of the new program year. There were 48 contracts renewed or extended. During the course of the fiscal year, there were a total of 38 modifications. The provider surveys and interviews showed that providers were very satisfied with the timeliness and efficiency of the contract process.

Provider Reimbursement

According to the Florida Prompt Payment Act, local government entities should process payments within 45 calendar days. To assess the length of time to process provider payments, a total of 1990 RWIS and 17 MOVEit invoice records were analyzed. Of those records, 132 (7.1 percent) were cancelled (for various reasons) and required re-submission by the provider seeking reimbursement. This rate is slightly higher than last years' rate of cancellation (6.6%). A total of 1,875 invoice records were then analyzed for length of processing.

- When looking at calendar days elapsed, 90.6 percent of invoices were paid within 45 days. This is a substantial improvement from last year, when the rate was 79.2 percent. This still means that one out of ten invoices did not meet the Florida Prompt Payment Act guideline, but it does represent a marked improvement.
- Of the 176 invoices that were longer than 45 days, 102 of the invoices (59.3 percent) were paid within 55 days.
- There were 132 invoices that were cancelled and had to be resubmitted. It is likely that all of these took significantly more than 45 days between the original submission and receipt of the resubmitted payment. Although the Grantee is not expected to process these under the same timeline, one can imagine that providers would be frustrated by this delay.

Summary and Recommendations:

This AAM found improvements in almost every area analyzed. Provider responses indicate higher satisfaction in all areas, significantly so in some aspects. Care Council responses were almost entirely 100 percent; those that decreased from 100 percent last year remained in the mid-90 percents. The process for both RFAs occurred on time, efficiently, and according to plan. Contracts were renewed and extended in time for the new fiscal year, and the number of modifications dropped nearly in half from the year before. More than 90 percent of invoices were paid within 45 days, a significant improvement from the 79.6 percent rate the prior year.

That is not to say the administration went perfectly. There were issues that occurred during this time period:

- There were issues with eligibility entry into RWIS that delayed invoice submissions for some providers.
- The change in eligibility function placed a burden of double data entry on provider agencies.
- An oversight during the Budget Amendment process resulted in roughly $150,000 being left unspent despite Grantee efforts to the contrary.

In these and other cases, the Grantee staff identified issues and problems, and worked with providers and the Care Council to try and resolve them. Interviews and surveys indicate that there was good communication around these issues and resolutions. This is a good model for how stakeholders should work together. Therefore, this AAM does not have any specific recommendations for improvement based on the activities in the 2012-13 fiscal year.

Background

The West Central Florida Ryan White Care Council (Care Council) has a critical role in identifying needs and prioritizing service areas to be funded by the West Central Florida Ryan White Program. The Care Council is comprised of a combined Part A Planning Council and Part B Consortia and acts on behalf of all services being provided through the Total Service Area (TSA). An Assessment of the Administrative Mechanism was conducted on behalf of the Care Council to determine the extent to which the Grantee is efficiently implementing its administrative duties. During the fiscal year under assessment, Part B funds were switched from being administered through Hillsborough County to the new Lead Agency, Florida Department of Health in Pinellas County. This AAM covers only the Part A administration, although it mentions Part B where there was overlap.

The Ryan White HIV/AIDS Treatment Modernization Act Part A Manual describes the process as:

"The planning council assesses the efficiency of the administrative mechanism, which entails evaluation of how rapidly funds are allocated. The purpose is to assure that funds are being contracted for quickly and through an open process, and that providers are being paid in a timely manner. The planning council should not be involved in how the administrative agency monitors providers.

…The planning council can also assess whether the services that have been procured by the grantee are consistent with stated planning council priorities, resource allocations, and instructions as to how to meet these priorities. However, assessing the administrative mechanism is not an evaluation of the grantee or individual service providers, which is a grantee responsibility."

Methodology

The Assessment of the Administrative Mechanism examines the allocations determined by the Care Council, contracting of those services, and reimbursement for those services. Data was collected through the following means:

- Provider Survey
- Care Council Survey
- Review of Care Council Approvals of Allocations and Re-allocations
- Review of Provider Contracts and Contract Amendments
- Review of Provider Invoices and Reimbursement Records
- Review of Committee Meeting Minutes
- Interviews with Grantee staff, provider staff, and Care Council members

Both the Provider Survey and the Care Council Survey questions were reviewed by the Resource Prioritization and Allocation Recommendations Committee (RPARC). The Health Council of East Central Florida announced the surveys via email, which provided a link to the web-based survey tool.

Timeframe for this AAM: Allocations and re-allocations for services provided in fiscal year 2012-2013 (FY 12-13) for Part A and Minority AIDS Initiative (MAI) funding were obtained through a review of Care Council meeting minutes. Contracted amounts with any subsequent amendments were documented through a review of FY 12-13 provider contracts.

Invoice and reimbursement data was collected for the time period of March 1, 2012 through June 30, 2013. All Ryan White invoices submitted through the Ryan White Information System (RWIS) during the specified timeframe were included in the analysis. Additionally, a sample of those invoices submitted through the MOVEIt system was also included. MOVEIt data was sampled from each quarter of the fiscal year.

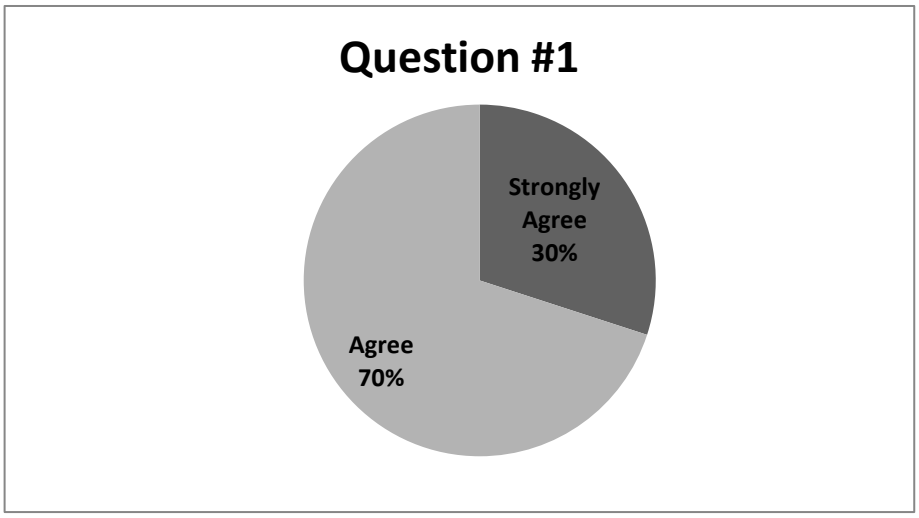
Results of Provider Survey and Interviews

The provider survey questions were reviewed by the Resource Prioritization and Allocation Recommendations Committee (RPARC) and a link to the survey was sent to a total of thirteen providers via email in July 2013. The survey was web-based and respondents had until July 30, 2013 to respond. Ten providers responded, for a response rate of 76.9 percent (compared to a response rate of 94.1 percent in the prior year). Providers were asked twelve questions and given an opportunity to provide additional comments at the end of the survey. Response options ranged from "strongly agree," "agree," "neutral," "disagree," and "strongly disagree" and "does not apply." "Does not apply" and blank responses were excluded from valid response calculations. In addition to the survey, provider staff members were interviewed.

The following results detail the provider responses and summarize any comments provided that relate to the individual topic. Response rates from the previous year are also provided for comparison, where there were 16-18 respondents for each question.

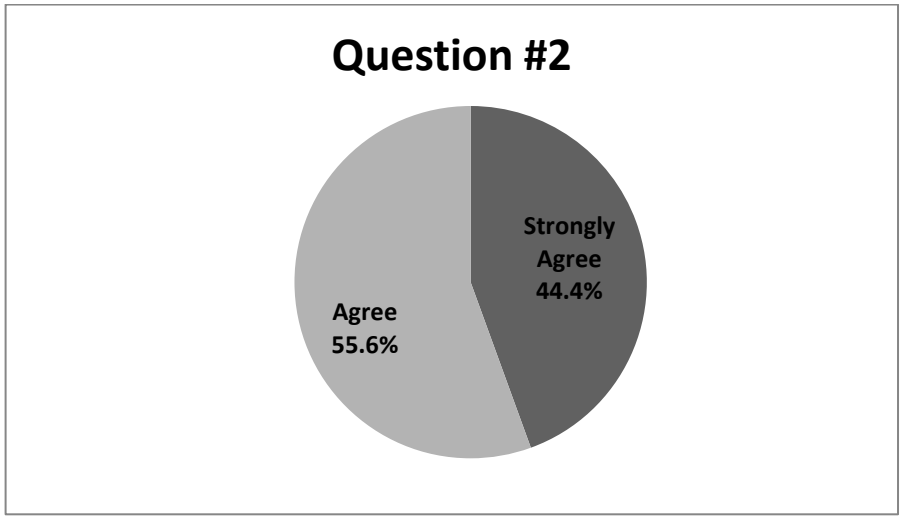
Q1: The Grantee Office staff conducted a timely and fair contract negotiation process with my agency.

Out of 10 respondents, all (100 percent) either agreed or strongly agreed that the Grantee Office staff managed a timely and fair contract negotiation process, an increase from the previous year (87.5 percent). No respondents chose to add a comment in the survey. Providers interviewed had very positive comments about the contract negotiation process, saying that it was consistent, predictable, fair, and efficient.



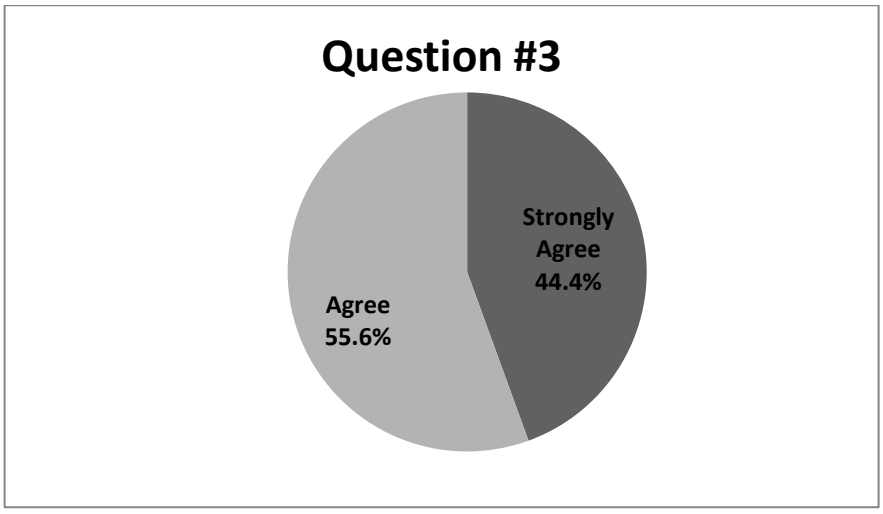
2: The Grantee Office staff executed my agency's contract in a timely and efficient manner, on or prior to March 1st, the start of the new fiscal year.

All respondents (9 out of 9) agreed or strongly agreed that the Grantee staff executed the agency's contract in a timely and efficient manner, on or prior to the start of the new fiscal year. This is up from 87.4 percent in the prior year and 81.3 percent the year before that. No one chose to comment on the contracting efficiency.



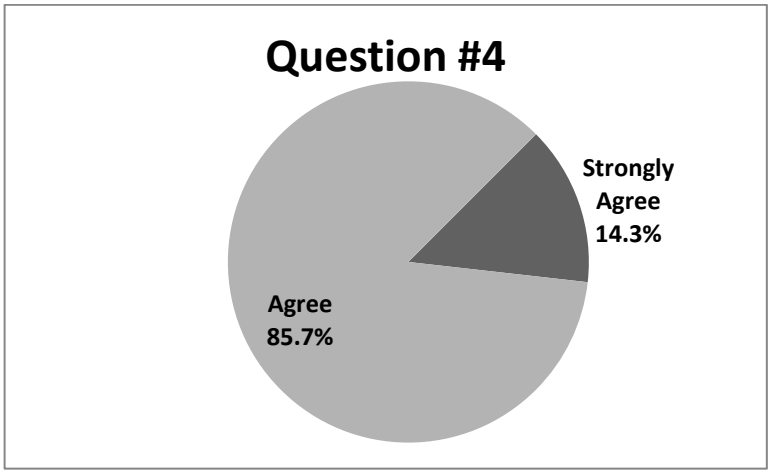
Q3: The Grantee Office staff executed amendments to my agency contract in a timely and efficient manner.

All respondents (100 percent) agreed or strongly agreed that contract amendments were timely and efficient. This is a change from last year, where only 75 percent, (12 out of 16) agreed or strongly agreed that contract amendments were timely and efficient. During the prior year, there was a marked increase in the number of amendments for Part A/MAI funds. This was largely due to partial funding and incorrect award notices from HRSA. This year there were far fewer amendments, and the satisfaction ratings here reflect that. The comments from providers during the interviews also reflected high levels of satisfaction with the timeliness and efficiency of the process.



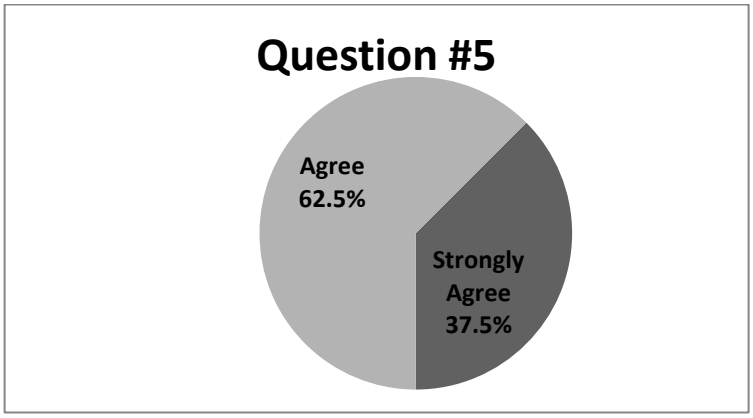
Q4: The Grantee Office staff contacted me to review my agency's utilization and expenditures and followed up with my agency if spending was not on target.

Overall, 7 out of 7 (100 percent) respondents agreed or strongly agreed, with three respondents choosing Not Applicable or not answering the question, possibly because a review of expenditure data is only conducted with providers if expenditures are below target. This rate of 100 percent is up significantly from 69.2 percent last year. No respondent chose to enter a comment.



Q5: On average, my agency receives payments from Hillsborough County Government for our invoices within 45 calendar days.

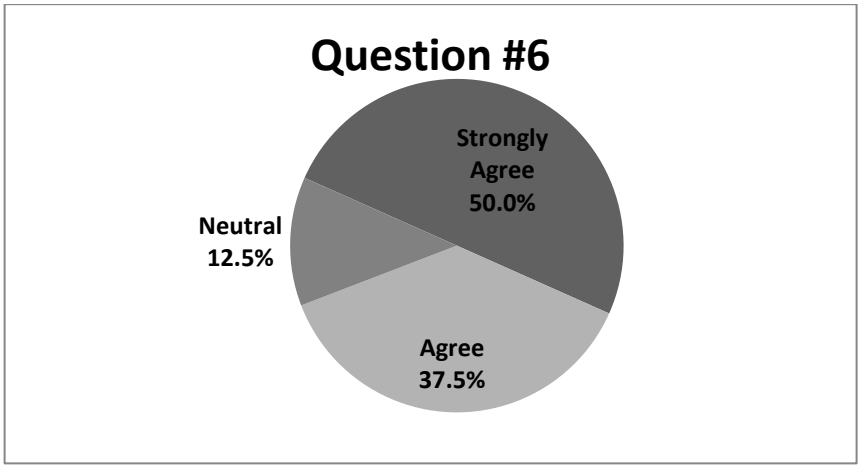
All respondents (100 percent) who answered this question agreed or strongly agreed that their agency received payment within 45 calendar days on average (8 out of 8), while two respondents chose not to answer the question. This is in stark contrast to last year, where only half (8 out of 16) agreed or strongly agreed. The prior year saw Grantee staff cuts and a reorganization, which impacted the timeliness of payments. The Grantee was back to normal with invoice processing for FY 12-13. During interviews, providers confirmed that invoice processing timeliness was fine during FY 12-13. All commented that during the current year of FY 13-14 (outside of the time range of this AAM) the invoice process changed and there were issues with the transition. This will be covered during the next AAM for FY 13-14.



Q6: The Grantee Office staff informed my agency of reallocation processes and the requirements of our spending plan in order to make necessary adjustments during the year.

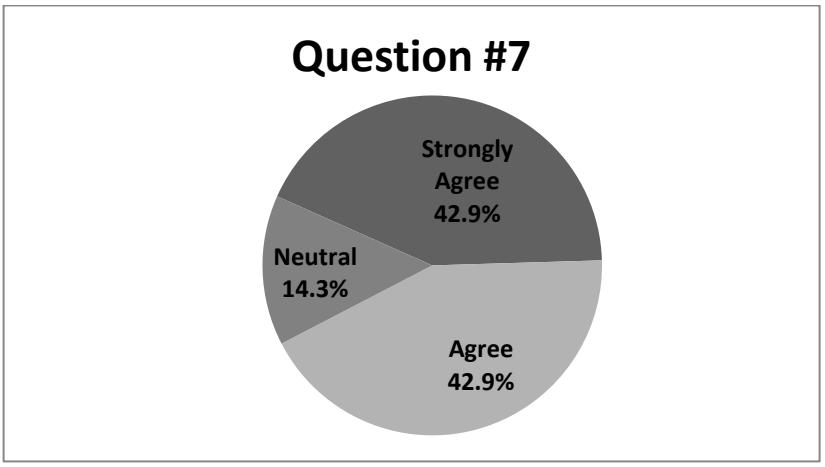
The majority of respondents, 87.5 percent, agreed or strongly agreed that the Grantee staff kept them informed of the reallocation process and spending plan requirements in order to make necessary adjustments during the year. One respondent was neutral and one did not respond. These responses are an improvement from last year, when 78.5 percent of valid responses agreed or strongly agreed.

Comments: One comment was made encouraging the Grantee to be more proactive regarding monitoring expenditures and the reallocation process to ensure that all funds are expended.



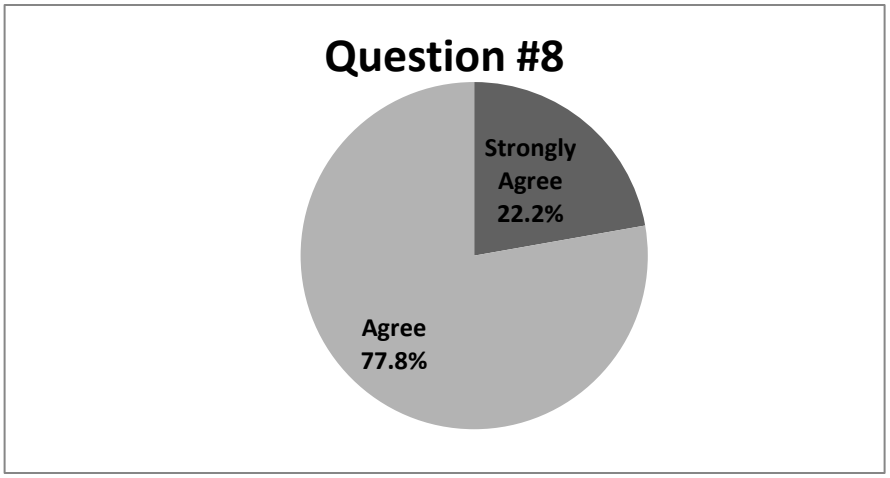
Q7: The Grantee Office staff provided technical assistance to my agency for completion of invoices, reports and other requirements as needed.

Six out of seven respondents (85.7 percent) agreed or strongly agreed that the Grantee Office staff provided technical assistance, as needed. One respondent was neutral. There were three respondents who marked Not Applicable or did not respond. This is an improvement over last year, when 71.5 percent agreed or strongly agreed, 14.2 percent were neutral, and 14.3 percent disagreed or strongly disagreed. No respondents chose to make a comment on the survey, but during the interview several providers were very complimentary toward the grantee staff. Comments included that they are knowledgeable, stay on top of all details, and are excellent in identifying solutions and resolving issues.



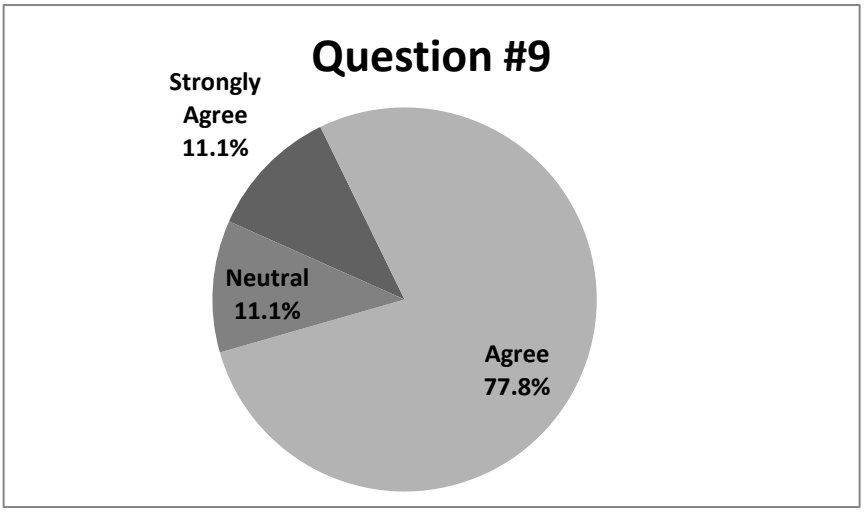
Q8: The Grantee Office staff provided our agency with a clear explanation of Ryan White Part A Program reporting requirements (i.e., Ryan White Services Report (RSR), client eligibility screening,, etc.).

All respondents (100 percent) agreed or strongly agreed that the Grantee Office staff provided a clear explanation of Ryan White Program reporting requirements. Last year, 87.4 percent agreed or strongly agreed. No respondents provided comments.



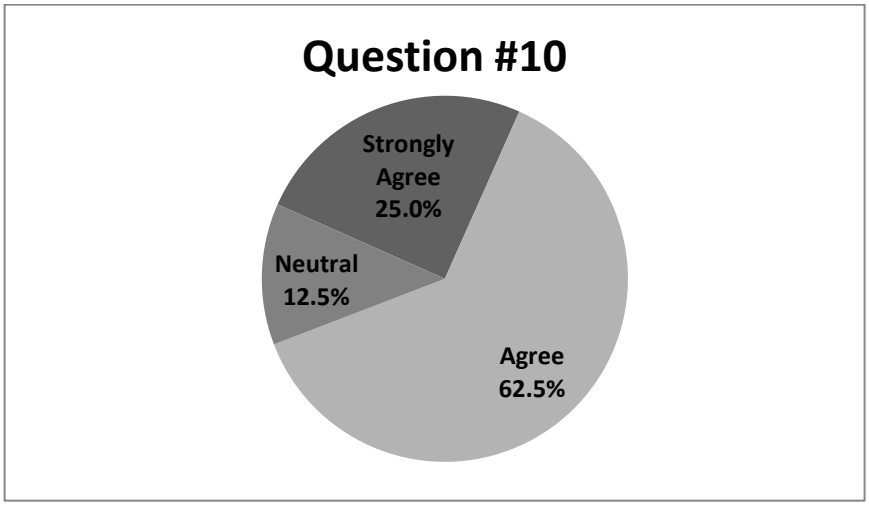
Q9: The Grantee Office kept our agency well informed of Health Resources and Services Administration (HRSA) policies, procedures and updates that impact Ryan White Part A Program providers.

Overall, 88.9 percent of respondents agreed or strongly agreed (8 out of 9) that the Grantee Office kept their agency well informed of HRSA policies, procedures and updates; one respondent was neutral Last year 81.2 percent agreed or strongly agreed, with two being neutral and one disagreeing. No respondents entered comments, but those interviewed praised the level of communication from the Grantee staff.

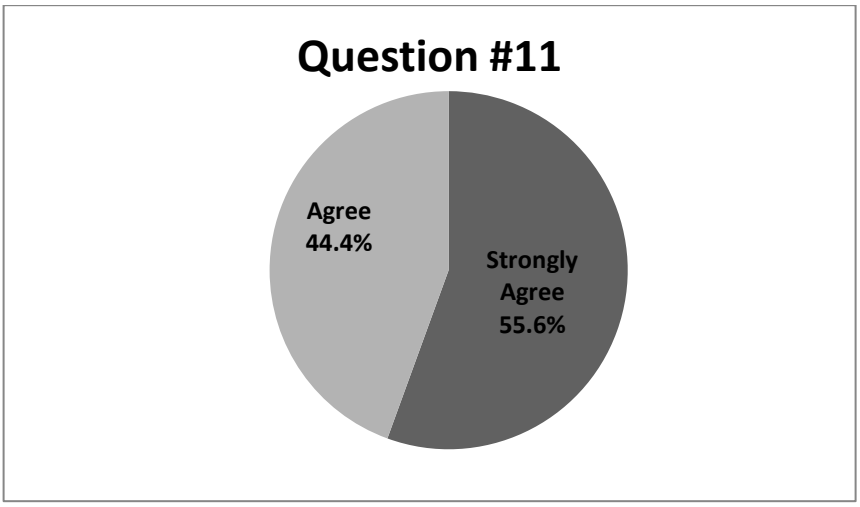


Q10: The Grantee Office kept our agency well informed of Care Council directives that impact Ryan White Part A Program providers.

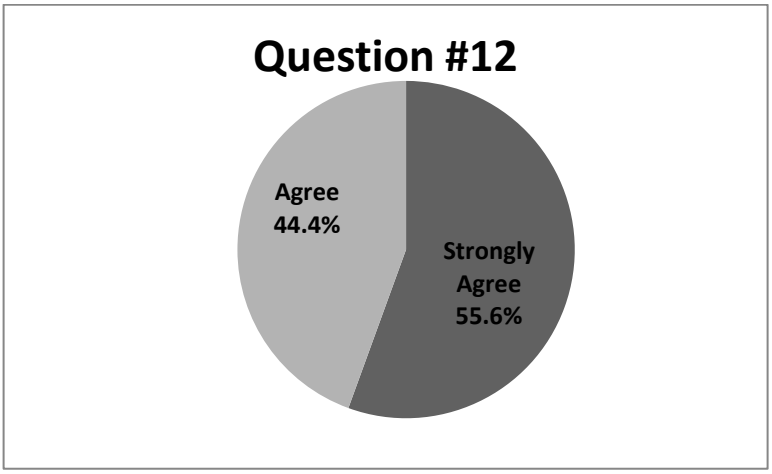
Of those responding, 87.5 percent of the respondents (7 out of 8) agreed or strongly agreed that the Grantee Office staff kept their agency well informed of Care Council directives that impact Ryan White Part A Program providers. One respondent was neutral; two did not respond. These are close to last year's results, when 81.2 percent agreed or strongly agreed. There were no comments entered.



Q11: Grantee Office staff is courteous and respectful.
All respondents (100 percent) agreed or strongly agreed that the Grantee Office staff were courteous and respectful. Last year, 18.8 percent of respondents were neutral; the remaining 81.2 percent agreed or strongly agreed. The interviewed providers were unanimous that the staff were helpful, easy to work with, and respectful.



Q12: The Grantee Office staff responded promptly and adequately to inquiries, requests and problem-solving needs from our agency.
All respondents (9 out of 9) agreed or strongly agreed that the Grantee Office staff responded promptly and adequately to inquiries, requests and problem-solving needs from their agency. Last year, only 75 percent (12 out of 16) agreed or strongly agreed. Three out of 16 (18.7 percent) of respondents disagreed or strongly disagreed with this statement, and one was neutral.



General Comments made by survey respondents:

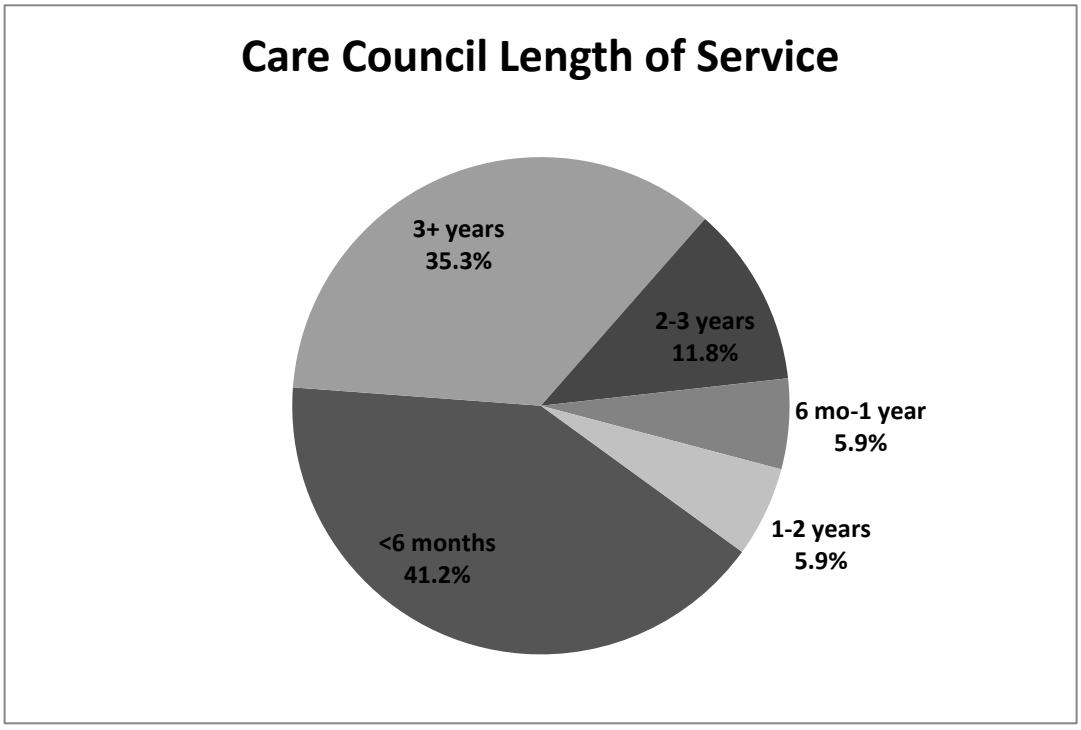
Only one respondent chose to make a comment at the end of the survey. This person commented that Grantee staff are always helpful.

Results of Care Council Member Survey and Interviews

The Care Council member survey questions were reviewed by the Resource Prioritization and Allocation Recommendations Committee (RPARC). The survey announcement was sent via email in July 2013 with a link to the web-based survey. Seventeen Care Council members out of twenty-four responded, generating a response rate of 70.8 percent (compared to a rate of 67.9 percent in the previous year). The deadline for surveys to be completed was July 30, 2013. In addition to the survey, four Care Council members were interviewed.

Care Council members were asked six questions and given an opportunity to provide additional comments at the end of the survey. Response options ranged from "strongly agree," "agree," "neutral," "disagree," "strongly disagree," and "does not apply."

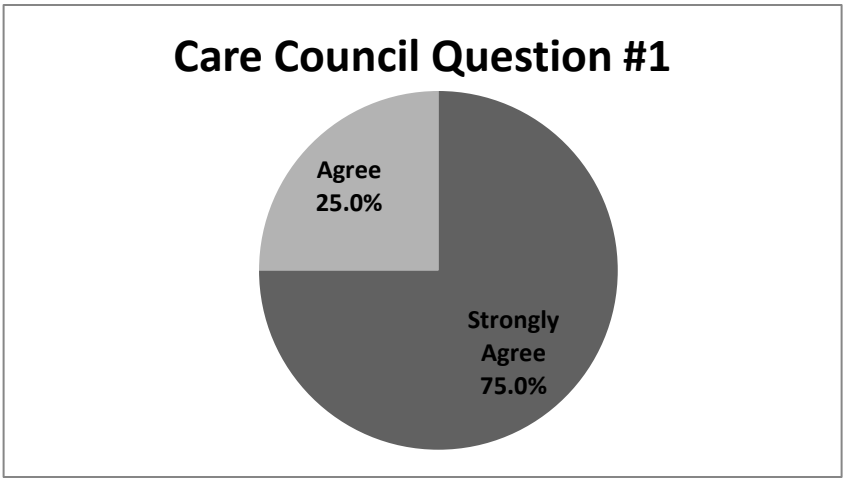
Respondents were also asked their length of service on the Care Council. The two largest groups were those with the shortest and the longest times: members with less than six months service (41.2 percent) and those with three or more years of service (35.3 percent).



The following results detail the Care Council responses to the survey questions and summarize any comments provided that relate to the individual topic.

Q1: The Grantee Office staff follows the Care Council's service priorities, resource allocations and re-allocations.

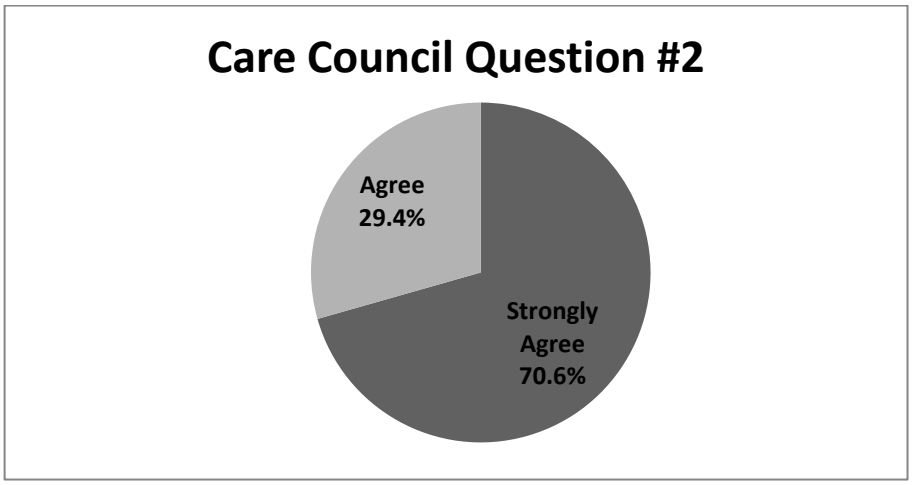
Sixteen respondents (100 percent) either agreed or strongly agreed that the Grantee Office staff follows the Care Council's service priorities, resource allocations and reallocations. One respondent marked "Does Not Apply." These results are similar to last year's results.



Comments: One survey respondent praised the Grantee staff. All members interviewed responded positively that the Grantee followed their priorities and allocation decisions.

Q2: The Grantee Office staff reports expenditure data to the Care Council on a quarterly basis.

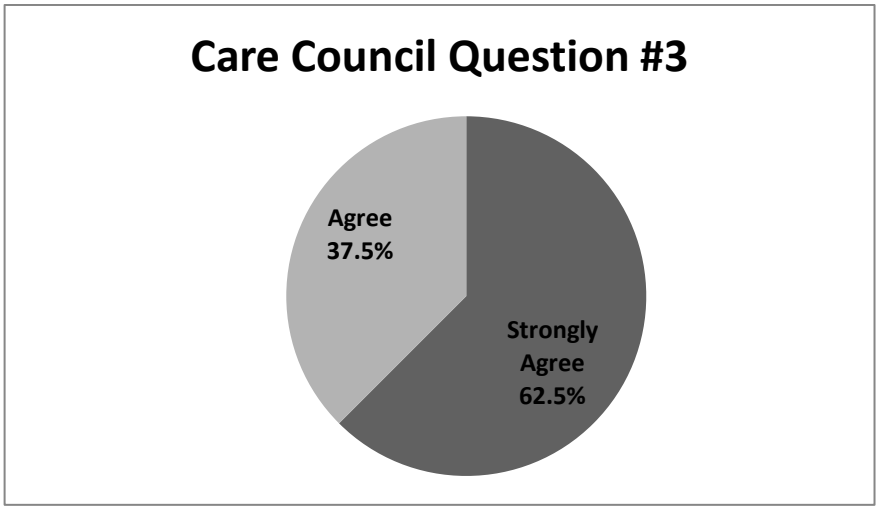
All seventeen respondents (100 percent) agreed or strongly agreed that the Grantee Office staff report expenditure data to the Care Council on a quarterly basis. The results were the same last year.



Comments: One person commented that, despite their short time on the Council, they had been very impressed by how engaged and forthcoming the Grantee was with information. All interviewed members had positive comments about the communication from the Grantee on expenditures.

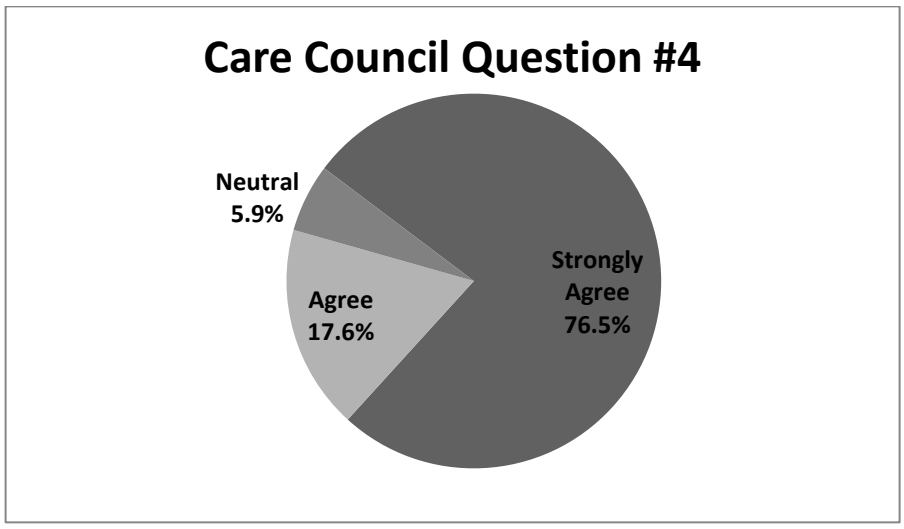
Q3: The Grantee Office staff promptly and adequately responds to questions from the Care Council on resource allocation, reallocation and expenditures.

All respondents (100 percent) agreed or strongly agreed that Grantee Office staff responds to resource allocation, reallocation and expenditure inquiries from the Care Council promptly and adequately. One respondent chose not to answer. Last year's responses were similarly positive.



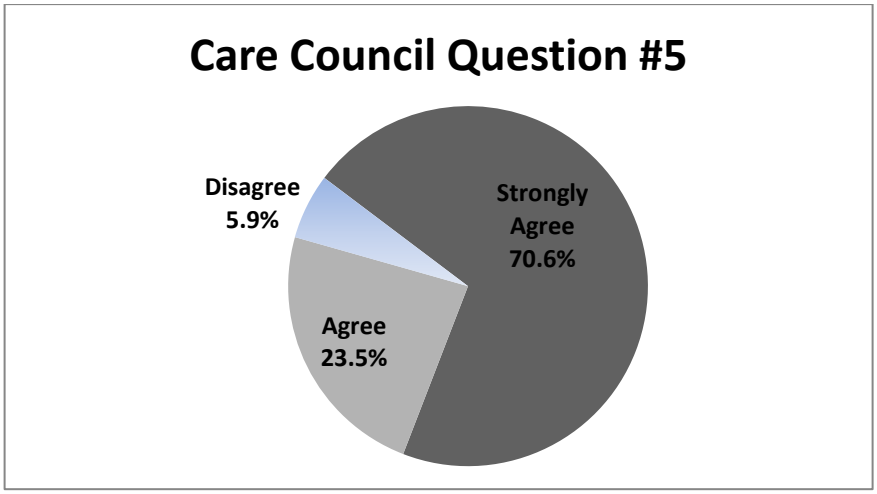
Q4: The Grantee Office staff clearly communicates to the Care Council about the reallocation process.

Sixteen respondents (94.1 percent) agreed or strongly agreed that the Grantee Office staff clearly communicates about the reallocation process to the Care Council, while one respondent was neutral. Last year all respondents agreed or strongly agreed.

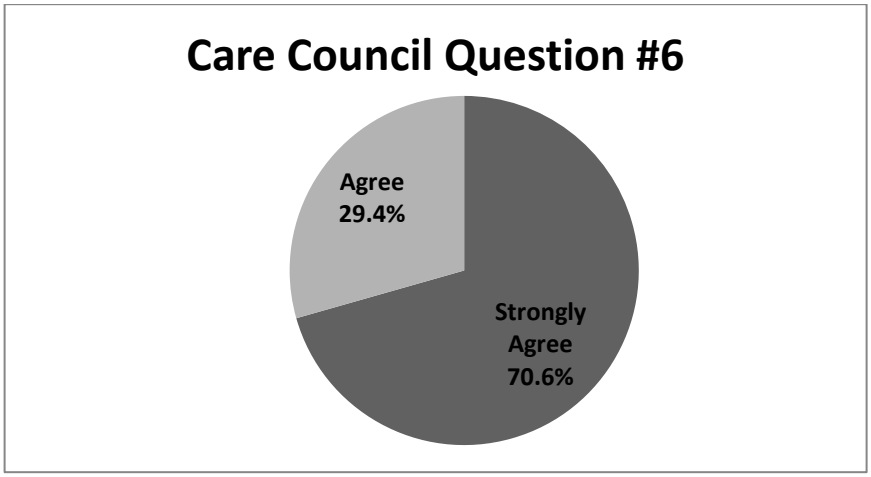


Comments: One respondent elaborated on the completeness of information provided. During the interviews, two respondents praised the Grantee for the level of communication around reallocations.

Q5: The Grantee Office staff effectively administers grant funds.
Sixteen respondents (94.1 percent) agreed or strongly agreed that the Grantee Office staff effectively administers grant funds. One respondent disagreed; no respondents entered a comment to elaborate. Last year 100 percent of those choosing to respond agreed or strongly agreed.



Q6: The Grantee Office staff keeps the Care Council well informed of HRSA policies, procedures and updates that impact the Ryan White Program.
All seventeen respondents agreed or strongly agreed that the Grantee Office staff keeps the Care Council well informed of HRSA policies, procedures and updates that impact the Ryan White Program. These results are similar to last year's responses.



General Comments:
Five respondents chose to leave general comments. All comments praised the Grantee on one or more areas including being knowledgeable, responsive, helpful, warm, welcoming, and diligent in their communication. They also complimented the approach and efforts of the Grantee staff.

Procurement/Request for Application (RFA) Process

The Board of County Commissioners (BOCC) for Hillsborough County approves a two-year budget in advance for the Ryan White Part A Program. The approved budget is entered into the Clerk of the Court's Financial Accounting Management Information System (FAMIS) and obligates funds for Part A and MAI prior to the HRSA Notice of Grant Award and Florida Department of Health contract.

Contracts for Ryan White services are procured through a Request for Application (RFA) process or are renewed annually for existing contracts. Services are procured on a five year contract cycle by service category and county, with contracts being renewed on an annual basis if providers meet performance criteria. If needed, RFAs are issued for services within the five year period if a new provider is required or new services are being procured.

Two RFAs were issued during calendar year 2012 to procure services for a five year contract cycle. One was based on additional funding from HRSA; the other was for Medical Case Management services in two areas. The following flowchart illustrates the average processing time for both RFAs.

RFA Process	RFA Issued in April 2012	RFA Issued in November 2012
RFA Advertised	4/2/12	11/26/12
Pre-submittal Conference	4/5/12 (3 days)	12/4/12 (8 days)
Requests for Interpretation	4/10/12 (5 days)	12/7/12 (3 days)
Deadline & Evaluation of Applications	4/27/12 (17 days)	12/28/12 (21 days)
Award Recommendations Posted	5/9/12 (12 days)	1/10/13 (13 days)
Grievances and Appeals	5/22/12 (13 days)	1/24/13 (14 days)
Board of County Commissioners Approval	6/6/12 (15 days)	2/20/13 (27 days)
TOTAL	**65 days**	**86 days**

There were 65 and 86 days from issuance of the RFA to BOCC approval. This is down from 160 days in 2011. In the provider survey, 100 percent of providers agreed that their contract was negotiated in a timely and fair process, and that contracts were executed in a timely and efficient manner. These results are an improvement from the prior year.

Adherence to Care Council Priorities

As previously noted, the AAM allows the Care Council to "*assess whether the services that have been procured by the grantee are consistent with stated planning council priorities, resource allocations, and instructions as to how to meet these priorities."* On June 2, 2011, the Care Council approved the *Service Caps/Limits and Eligibility* as a separate document from the previous *Minimum Standards of Care and Service Caps* document.

The *Service Caps/Limits and Eligibility* document is reviewed annually by the Care Council and revised as needed. The following table (approved February 6, 2013) illustrates the current service caps/limits for those currently funded service categories. The Grantee uses these caps when soliciting proposals for services. The RFA includes the service caps and requires providers to adhere to them. All Care Council members that responded to the survey agreed that the Grantee Office follows the Care Council's service priorities.

Currently Funded Service Category	Cap/Limit	Eligibility Exceptions
Note: "Common Criteria" eligibility for all services is: HIV positive, proof of residency, proof of income, and income <400% Federal Poverty level (FPL), except where noted.		
Food Bank/Nutritional Supplements	No cap/limit established	Income <150% Federal Poverty level (FPL) which includes a provision for waiver when required
Transportation	No cap/limit established	Common Criteria Only
Substance Abuse	No cap/limit established	Common Criteria Only
Mental Health	No cap/limit established	Common Criteria Only
Drug Reimbursement	No cap/limit established	Common Criteria Only
Health Insurance	Enrolled clients receive up to $275/month for co-pays and up to $400/month for COBRA, group and individual insurance premium payments	Common Criteria Only Note: Grantee has the authority to increase caps when necessary to ensure all funds are utilized for the grant period
Oral Health	$2,000 Covered services are limited to: exams, x-rays, fillings, extractions, cleanings (prophylaxis, scaling and root planing, gross debridement), dentures (partial or full) and oral health instruction.	Common Criteria Only Note: Grantee considers exceptions on a case by case basis only if medically necessary
Primary Care	No limit on office visits or labs	Babies born to HIV positive mothers (pediatric indeterminate) may be served until 2 years of age Must be receiving primary care from a Ryan White funded provider
Patient Education/Treatment Adherence*	No more than 25% of total primary care contract may be used for patient education. (*The Care Council designated pregnant women, infants, children and adolescents as special populations and does not include them in the service cap for primary care patient education)	
Treatment Adherence	No cap/limit established	Available only to Minority AIDS Initiative (MAI) clients
Case Management	$2,400	Common Criteria Only Grantee considers exceptions on a case by case basis
Case Management (non-medical)	No cap/limit established	State Eligibility Rule 64D allows a one-time exception

Other priorities identified by the Care Council in regard to contracting for services are discussed with the Grantee Office when establishing criteria for the RFAs and contract renewals. Care Council priorities are also discussed during the priority setting and resource allocation process that occurs annually.

Care Council Allocations and Reallocations

The grant year for Part A begins March 1st of each year. HRSA notifies the Grantee of the award amount, usually sometime in March. For 2012-13, HRSA made the grant award in full, with the notice coming in early March, 2012. The Care Council was notified on March 7, 2012 that there was an increase of 1.7% in the Part A Supplemental Award. This timing is an improvement over the prior year, when funding and budget issues at the federal level caused HRSA to make a partial award in March 2011, a final award notification in mid-July, and then a corrected final award in late July.

The initial allocations had been made by RPARC in September 2011, to allow the procurement process to proceed in time for the start of the new fiscal year. Based on the March 2012 award notice, a new set of allocations was approved by the Care Council on April 4, 2012. This included the additional funding, and an RFA was issued for bids to provide the services funded by the increase.

Funds were then reallocated in August 2012 to reflect the change in Part B Lead Agency over to the Florida Department of Health in Pinellas County. A second reallocation occurred in October 2012, based on expenditure patterns for the year. The final reallocation, approved by the Care Council in December 2012, reflected the expenditure projections for the year. In February, the Grantee also made the typical year-end reallocations (sweep) in order to provide as many services as the funding would support.

Several categories had a variation greater than 2 percent between the initial allocation and the final total expenditure. This is in contrast to prior years, where only one or two categories had larger than two percent variances. There was not a system-wide issue, but rather a series of issues or situations.

- Non-Medical Case Management was 1.1% under allocation. This category was originally allocated more than the prior year, because the eligibility verification burden was increased and additional staff would be needed. When the Part B Lead Agency role moved to the Florida Department of Health in Pinellas County, the Care Council decided to make all eligibility activities occur under Part B funds. Therefore, there was a decrease in Part A allocations in this category. The decrease was offset by moving some Part B funds into other Part A categories, for no net change in total funds.
- Grantee Admin & Support was 2.7 percent under allocation. The funds were originally intended to update hardware for RWIS. However, it was determined mid-year to wait on those upgrades until later, if needed at all.
- Pharmaceutical assistance was reduced by 2.5 percent, because the needs of clients were being partially met through other funding sources and because the dispensing fees were lower under the sole provider than they had been when there were two providers.
- These savings were put into high-priority categories based on Care Council directions.

Part A FY 12-13 (includes MAI)

Service Category	Percent of Total Initial Allocation	Percent of Total Final Reallocation	Percent of Total Expenditure	Variance between Initial and Expended
Outpatient Ambulatory Medical Care	35.0%	35.6%	36.1%	1.1%
Pharmaceutical Assistance	15.7%	13.0%	13.2%	-2.5%
Medical Case Management	12.7%	15.1%	15.3%	2.7%
Oral Health	5.7%	7.8%	7.9%	2.2%
Health Insurance	5.4%	5.3%	5.4%	0.0%
Substance Abuse	4.3%	4.3%	4.4%	0.1%
Substance Abuse (MAI)	1.3%	1.3%	1.3%	0.0%
Mental Health	2.6%	2.7%	2.8%	0.2%
Treatment Adherence (MAI)	4.4%	4.4%	4.5%	0.1%
Non-Medical Case Management	2.4%	1.2%	1.3%	-1.1%
Grantee Admin & Support	10.5%	9.3%	7.8%	-2.7%

Note: Part A Funding includes formula funding, supplemental funding and MAI funding.
Note: Grantee Admin includes Planning Council Support, RWIS Support, and Quality Management

The Grantee and the Care Council expended 98.2% of Part A funds this fiscal year. The vast majority of unspent funds were in the Grantee Administration and Support Category. Of the almost $173,000 of unspent funds, $154,000 were in this category (89%). Planned upgrades to the RWIS hardware were delayed, and therefore the Grantee processed a Budget Amendment in order to reallocate these funds. However, due to an oversight during the Budget Amendment process, the funding that we was intended to be used for hardware/MIS purposes was placed in a different line/character. Once the problem was discovered, it was too late to revise. It is to the benefit of the Ryan White consumers for the program to fully spend all grant dollars, so the maximum amount of services can be provided. Two years ago (2010-11), Part A expended all but 0.87% of its award, but in 2011-12 it did not spend 1.9% of its award. This year it left 1.8% unspent. It is unfortunate that the county administration could not correct the oversight in time to spend those funds on services. Despite this, the Grantee did expend more than 98% of the grant funds (an important benchmark for future funding).

All of the Care Council survey respondents (100%) agreed that the Grantee Office staff follows the Care Council's allocations and reallocations; and promptly and adequately responds to questions about allocation, reallocation and expenditures. In addition, 94.1% of respondents agreed that the Grantee Office clearly communicates about the reallocation process, with one neutral response. Care Council members that were interviewed all agreed that the Grantee Office is faithful to the directions and priorities of the Care Council.

Contracts and Contract Modifications

The Grantee Office submits the details for new contracts and annual contract renewals to the Office of the County Attorney for review. The Community Service Program Manager prepares the contract and obtains the provider's signature. Signed contracts are presented at the scheduled Board of County Commissioners (BOCC) meeting for approval and contract execution. Executed contract details are then entered into the Clerk of the Court's Financial Accounting Management Information System (FAMIS) and the Ryan White Information Management System (RWIS).

There were 48 contracts renewed/extended at the February 22, 2012 BOCC meeting, in preparation for the 2012-13 fiscal year that was to begin on March 1, 2012, six days later.

Reallocations by the Care Council are executed as modifications to existing provider contracts. Modifications below $100,000 can be approved by the Director of Family and Aging Services and subsequently reported to BOCC. This process by which approvals are made by the Director of Family and Aging Services and reported to the BOCC has increased efficiencies by removing possible delays related to waiting for modifications being placed on the BOCC calendar. Once modifications are approved, changes to the contract details are also made in RWIS by the RWIS Coordinator and in FAMIS by the Accountants

Change in Lead Agency

In late 2011, the Surgeon General of the Florida Department of Health issued a directive that all Part B dollars must be competitively bid. At this time, Hillsborough County was the Lead Agency for Part B as well as the Grantee for Part A and MAI funds. The State chose to extend current Part B contracts (including Hillsborough County) through September 2012 to allow themselves time for guidance to be issued, applications to be written and evaluated and Lead Agencies to be selected.

However, local health departments were exempted from having to compete. The Florida Department of Health in Pinellas County chose to exercise their option to have the Lead Agency function occur internally, and so no competitive bidding process occurred. In April 2012 it was announced to the Care Council that the Part B Lead Agency status for the region was moving to the Florida Department of Health in Pinellas County (herein called the Lead Agency in Pinellas County).

The staff in Hillsborough County worked with the new staff at the Lead Agency in Pinellas County to transition the administration of the Part B funds. The Lead Agency in Pinellas County determined that they would not do a procurement process for the remainder of the fiscal year, but would instead develop new contracts with the existing providers. The goal was for contracts and services to transfer over "as is" and to remain unaffected, and the Care Council would continue to be a single entity administering Part A, Part B, and MAI funds, just as it has in the past.

The Care Council discussed the transition at length during their August 1, 2012 meeting. They recommended a "realignment" to shift some contracts between Part A and Part B. This was done to simplify reporting, billing, and contracting. In addition, it was done to allow all eligibility to be performed under Part B, so that all data could be entered into the state's CareWare system. This resulted in approximately $230,000 moving from Part A to Part B or vice versa. The funds stayed with the same providers, it was just moved between Parts.

Interviews with providers, Care Council members, and staff at the Grantee and Lead Agency in Pinellas County indicate that the transition was largely smooth. There were compliments for staff in both counties on their professional and pro-active efforts during the transition. Consumers were largely unaware of the switch, according to the interviewees. There were some technical hurdles in fully implementing the program in the Lead Agency in Pinellas County administration, notably around reporting and reimbursement of invoices. This did involve some frustration. However, the staff worked through these and communicated proactively.

Contracts and contract modifications for FY 12-13 were reviewed for timely execution and alignment with the approvals of the Care Council. A total of 49 Part A contracts were reviewed and are summarized below.

Funding Source	Number of Contracts	Number of Contract Modifications This Year (2012-13)	Number of Contract Modifications Last Year (2011-12)
Part A & MAI	49	38	63

The number of modifications in the prior year, 2011-12, was unusually high. This was due in large part to a partial award and incorrect award announcements from HRSA. The number of modifications two years prior, in 2010-11, was 20. Modifications are necessary in order to maximize the use of grant funds, however, it is better for all involved to keep the number of modifications low. It is more efficient and reduces administrative time spent on contract processing. In addition, it allows providers to plan better and make fewer forced mid-year adjustments.

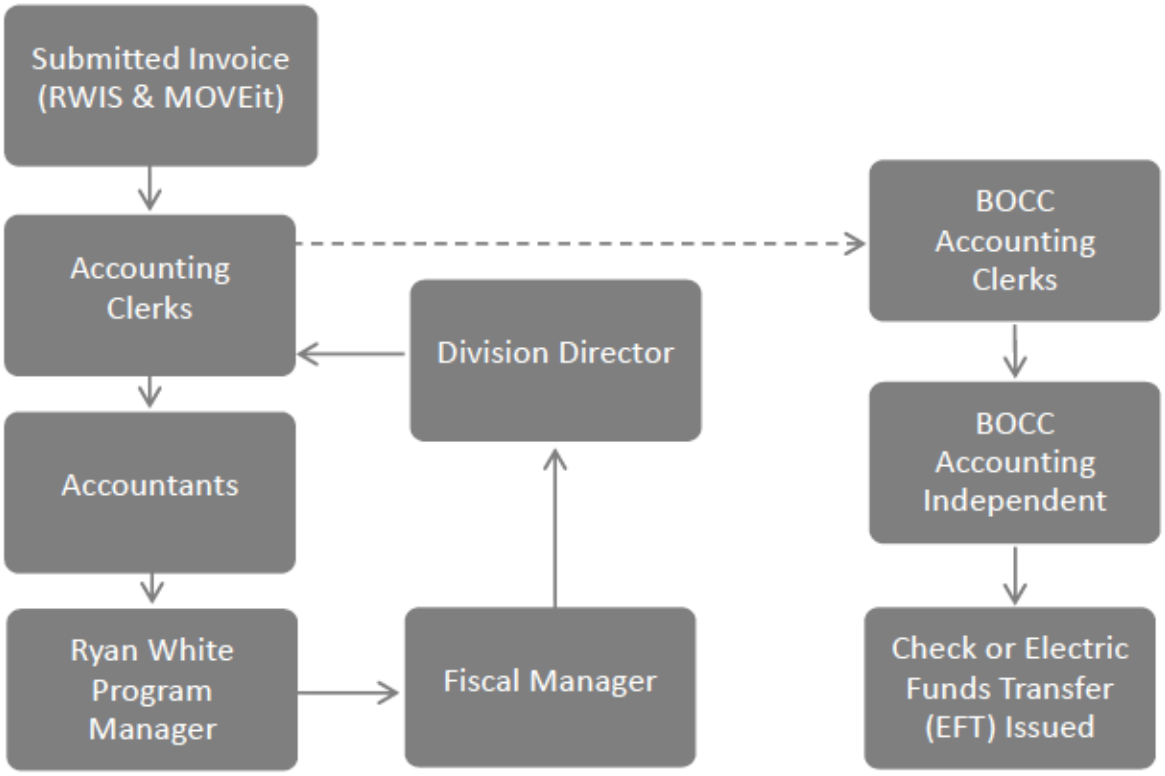
Provider Reimbursement

During the period under review, providers were reimbursed utilizing two different processes, with the majority submitted through RWIS. These two processes are similar to those used in prior years. **Please note that the process in place during this AAM time period (and therefore described below) has since been changed** due to a new financial system in the county Clerk's office. The change falls into the next AAM time period and so will not be discussed until next year's report.

The process in place during FY 2012-13 is as follows: individual claims being sought for reimbursement are identified within RWIS and submitted as batched invoices. The majority of providers bill monthly on specific dates, with some providers invoicing semi-monthly. If all criteria is met (i.e., spending caps have not been exceeded, insurance status, additional contract specifications, etc.), batched claims will be sent to the Ryan White Accounting Clerks. If reimbursement criteria are not met, a denial on the specific claim will be issued by RWIS. The remainder of the claims will then be sent to the Ryan White Accounting Clerks.

Accounting Clerks subsequently review 5 percent of the submitted claims for accuracy. Claims can also be manually denied by the Accounting Clerk if processing criteria is not met. Those claims that are approved by the Accounting Clerks are then submitted to the Ryan White Accountants for review and approval. Accountants also review 5 percent of submitted claims for accuracy. Batch claims are then sent to the Ryan White Program Manager, the Fiscal Manager and Division Director for approvals. The Division Director will then forward the approved claims to the Ryan White Accounting Clerks. The Ryan White Accounting Clerks will then submit a payment request to BOCC Accounting. The BOCC Accounting Clerks then review the claims and will communicate with the Ryan White Accountants if additional verification or documentation is required. If all documentation is accepted, BOCC Accounting conducts an independent verification of the claim against the provider's contract and issues a payment either as a paper check or electronic file transfer (EFT).

The second process utilizes MOVEit, an electronic file transfer program that applies to the pharmaceutical assistance provider. This provider utilizes MOVEit to submit their invoices and supporting documentation. The remaining reimbursement process mirrors that of an RWIS submitted claim. The following flow chart illustrates the various steps for processing a claim. At any point in the process, a claim may be denied or a request for additional information may be issued to the provider.



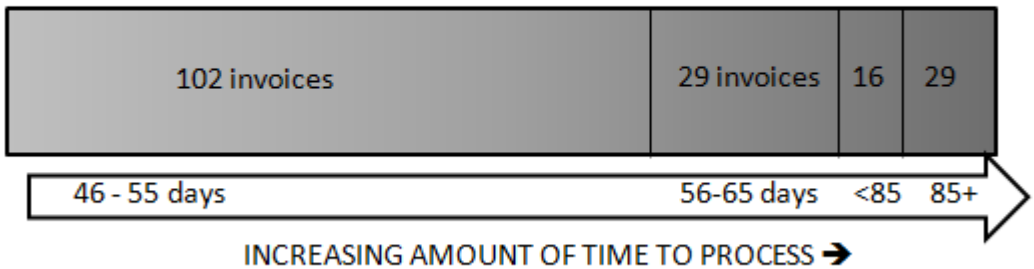
According to the Florida Prompt Payment Act, local government entities should process payments within 45 calendar days.

To assess the length of time to process provider payments, a total of 1990 RWIS and 17 MOVEit invoice records were pulled from the two systems. Of those records, 132 (7.1 percent) were cancelled (for various reasons) and required re-submission by the provider seeking reimbursement. This rate is slightly higher than last years' rate of cancellation (6.6%). A total of 1,875 invoice records were analyzed for length of processing.

Calendar Days Processing Time	**RWIS**		**MoveIT**		**Total Result This Year (2012-13)**		Total Result Last Year (2011-12)	
	Count	Percent	Count	Percent	**Count**	**Percent**	Count	Percent
45 Days or Fewer	1686	90.7%	13	76.5%	**1699**	**90.6%**	1748	79.2%
46 Days or more	172	9.3%	4	23.5%	**176**	**9.4%**	458	20.8%
Total	1858	100%	17	100%	**1,875**	**100%**	2206	100%

- When looking at calendar days elapsed, 90.6% of invoices were paid within 45 days. This means that one out of ten invoices did not meet the Florida Prompt Payment Act guideline.
- This is a significant improvement over the prior year, where only 79.2% were paid within 45 days.
- The chart below shows the number of invoices that were over 45 days, grouped by length of time to process.

Amount of time to process invoices that took more than 45 days.



(There were 176 invoices total that were over 45 days)

There were also 132 invoices that were cancelled and had to be resubmitted. It is likely that all of these took significantly more than 45 days between the original submission and receipt of the resubmitted payment. Although the Grantee is not expected to process these under the same timeline, one can imagine that providers would be frustrated by this delay.

The prior AAM (2011-12) included two recommendations related to invoice processing. A division reorganization and a reduction in staff had contributed to a much lower rate of efficiency; 1 in 5 invoices were not processed within 45 days. The AAM recommendations were to continue efforts to make the process more efficient and timely; and to share the AAM recommendation with management so they were aware of the impact of the reorganization and reduction in staff. The Grantee concurred with both of these recommendations in a response dated April 5, 2013 and described efforts to continue the improvements. The results from this year's AAM show the positive results of their efforts.

There was an issue related to eligibility which caused frustration for providers trying to submit invoices. The Notice of Eligibility (NOE) is the certification that a client's documentation has been verified and they are eligible for services for a specific time period. A change in Part B rules required specific eligibility verification to be conducted every six months. In order to make it more efficient, the Care Council and the provider agencies agreed that all Ryan White providers would follow the Part B eligibility requirements and timing. However, there were issues related to eligibility which impacted invoicing and reimbursements.

First, RWIS was programmed to require a current NOE in order to access a record and enter services for reimbursement/payment. An expired NOE locked out all provider agencies from entering their invoices even if the service was provided during a valid period. They were forced to track down which agency was responsible for entering the NOE and request that it be updated, and then wait for that to occur before they could invoice for the service. This extra time and effort was frustrating and inefficient, according to provider interviews, and it caused delays in receiving their payments.

The Grantee took provider feedback on this issue and requested a change in RWIS from the IT department. The change was to not lock out providers from records even if the NOE wasn't current. This programming change was made in the fall of 2012 and solved this inefficiency.

The second issue was that the eligibility information was needed in both RWIS (for Part A billing) and CareWare (for entry of Part B services). Although Part B agencies would do all eligibility checking, the information was still required in RWIS for Part A providers. Therefore, the agencies needed to do duplicate entry of the eligibility: once into RWIS and again into CareWare. It was agreed that the Part B agencies would be able to be reimbursed for this duplicate entry into RWIS and so would not have to shoulder the inefficiency of double entry without compensation.

In both cases, the Grantee Office and the Lead Agency staff worked cooperatively to address these issues and find resolutions so the program was as efficient as possible.

Finally, it should be remembered that this AAM review included invoices submitted for payment through June 2013. The survey of provider satisfaction was also conducted in the summer of 2013, and satisfaction was high. Also in the summer of 2013, Hillsborough County Clerk's Office joined other municipalities in switching to a new shared financial management system. Initial reports from this change indicate that providers are experiencing delays in receiving their reimbursements. However, this timeframe falls into the next AAM (2013-14) and so complete analysis and findings must wait until then.

Summary and Recommendations:

This AAM for 2012-13 found improvements in almost every area analyzed. Provider responses indicate higher satisfaction in all areas, significantly so in some aspects. Care Council responses were almost entirely 100 percent; those that decreased from 100 percent last year remained in the mid-90 percents. The process for both RFAs occurred on time, efficiently, and according to plan. Contracts were renewed and extended in time for the new fiscal year, and the number of modifications dropped nearly in half from the year before. More than 90 percent of invoices were paid within 45 days, a significant improvement from the 79.6 percent rate the prior year.

That is not to say the administration went perfectly. There were issues that occurred during this time period:

- There were issues with eligibility entry into RWIS that delayed invoice submissions for some providers.
- The change in eligibility function placed a burden of double data entry on provider agencies.
- An oversight during the Budget Amendment process resulted in roughly $150,000 being left unspent despite Grantee efforts to the contrary.

In these and other cases, the Grantee staff identified issues and problems, and worked with providers and the Care Council to try and resolve them. Interviews and surveys indicate that there was good communication around these issues and resolutions. This is a good model for how stakeholders should work together. Therefore, this AAM does not have any specific recommendations for improvement based on the activities in the 2012-13 fiscal year.

Appendix A: Reallocations for FY 2012-13

Date of Care Council Approval	Service	County	Reallocation
August 1, 2012	Non-Medical Case Management	Pinellas	90,000 from Part A to B
	Non-Medical Case Management	Hillsborough	90,000 from Part A to B
	Pharmaceutical Assistance	EMA	33,000 from Part B to A
	Oral Health Care	Pinellas	92,000 from Part B to A
	Outpatient/Ambulatory	Pinellas	55,000 from Part B to A
	Medical Case Management	Pasco/Hernando	53,675 from Part A to B
October 3, 2012	Outpatient/Ambulatory (Carry Over)	Hillsborough	+55,958
	Outpatient/Ambulatory (Carry Over)	Pinellas	+50,000
	Medical Case Management (Carry Over)	Pinellas	+50,000
	Treatment Adherence AA MAI (Carry Over)	Pinellas	+3,163
	Pharmaceutical Assistance	EMA	-250,000
	Outpatient/Ambulatory	Pinellas	-34,080
	Outpatient/Ambulatory	Hillsborough	-150,000
	Mental Health	Hillsborough	-35,000
	Outpatient/Ambulatory	Pinellas	-10,000
	Treatment Adherence Hispanic MAI	Pinellas	-11,000
	Outpatient/Ambulatory Specialty	Hillsborough	+44,042
	Outpatient/Ambulatory	Pasco	+12,000
	Medical Case Management	Hillsborough	+50,000
	Medical Case Management Inmate	Hillsborough	+10,000
	Medical Case Management Inmate	Pinellas	+10,000
	Medical Case Management	Pinellas	+25,000
	Medical Case Management	Pasco	+50,000
	Oral Health	Hillsborough	+77,519
	Oral Health	Pinellas	+76,519
	Mental Health	Hillsborough	+25,000
	Mental Health	Pinellas	+30,000
	Substance Abuse	Hillsborough	+19,000
	Substance Abuse	Pinellas	+50,000
	Treatment Adherence AA MAI	Pinellas	+11,000
	Outpatient/Ambulatory	Pinellas	+55,000
	Pharmaceutical Assistance	EMA	+33,000
	Case Management Eligibility	Hillsborough	-90,000
	Case Management Eligibility	Pinellas	-90,000
	Oral Health	Pinellas	+92,000

Appendix B: Survey instruments

Introduction to Provider Survey
Ryan White Provider,

We ask your participation and assistance by completing the following survey by June 14, 2013. Please note that all information will remain confidential and respondent results will be presented in an aggregate form only.

If you have any questions about the survey, please contact David Cavalleri, Ryan White QM Consultant, at dcavalleri@hcecf.org or 407-977-1610 ext. 225.

1. The Grantee Office conducted a timely and fair contract negotiation process with my agency.
   Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

2. The Grantee Office executed our agency's contract in a timely and efficient manner on or prior to March 1st, the start of the new fiscal year.
   Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

3. The Grantee Office executed amendments to my agency contract in a timely and efficient manner.
   Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

4. The Grantee Office staff contacted me to review my agency's utilization and expenditures data agency if spending was not on target.
   Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

5. On average, my agency receives payments from Hillsborough County Government for our invoices within 45 calendar days.
   Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

6. The Grantee Office staff informed my agency of reallocation processes and the requirements of our spending plan in order to make necessary adjustments during the year.
   Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

7. The Grantee Office staff provided technical assistance to my agency for completion of invoices, reports and other requirements as needed.
   Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

8. The Grantee Office staff provided our agency with a clear explanation of Ryan White Part A Program reporting requirements (i.e., Ryan White Services Report (RSR), client eligibility screening, etc.).
   Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

9. The Grantee Office kept our agency well informed of Health Resources and Services Administration (HRSA) policies, procedures and updates that impact Ryan White Part A Program providers.
   Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

10. The Grantee Office kept our agency well informed of Care Council directives that impact Ryan White Part A Program providers.
    Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

11. Grantee Office staff is courteous and respectful.
    Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

12. The Grantee Office staff responded promptly and adequately to inquiries, requests and problem-solving needs from our agency.
    Strongly Agree Agree Neither Agree or Disagree Disagree Strongly Disagree

13. Please share any additional comments below.

Thank you for completing the survey!

Any questions or comments can be directed to David Cavalleri, Ryan White QM Consultant, at dcavalleri@hcecf.org or 407-977-1610 ext. 225.

Introduction to Care Council Survey

Care Council Member,

We ask your participation and assistance by completing the following survey by July 30, 2013. Please note that all information will remain confidential and respondent results will be presented in an aggregate form only.

If you have any questions about the survey, please contact David Cavalleri, Ryan White QM Consultant, at dcavalleri@hcecf.org or 407-977-1610 ext. 225.

Survey Questions:

1. The Grantee Office staff follows the Care Council's service priorities, resource allocations and re-allocations.
   Strongly Agree Agree Neither Agree or Disagree Strongly Disagree

2. The Grantee Office staff reports expenditure data to the Care Council on a quarterly basis.
   Strongly Agree Agree Neither Agree or Disagree Strongly Disagree

3. The Grantee Office staff promptly and adequately responds to questions from the Care Council on resource allocation, re-allocation and expenditures.
   Strongly Agree Agree Neither Agree or Disagree Strongly Disagree

4. The Grantee Office staff clearly communicates to the Care Council about the reallocation process.
   Strongly Agree Agree Neither Agree or Disagree Strongly Disagree

5. The Grantee Office staff effectively administers Part A grant funds.
   Strongly Agree Agree Neither Agree or Disagree Strongly Disagree

6. The Grantee Office staff keeps the Care Council well informed of HRSA policies, procedures and updates that impact the Ryan White Program.
   Strongly Agree Agree Neither Agree or Disagree Strongly Disagree

7. Please share additional comments:

Thank you for completing the survey!

Any questions or comments can be directed to David Cavalleri, Ryan White QM Consultant, at dcavalleri@hcecf.org or 407-977-1610 ext. 225.