ATTACHMENT I

A. Services to be Provided

1. Definition of Terms

a. Contract Terms. Contract Terms used in this document can be found in the Florida Department of Children and Families Glossary of Contract Terms, which is incorporated herein by reference, maintained in the contract manager's file, and located at the following website:

http://www.dcf.state.fl.us/admin/contracts/docs/GlossaryofContractTerms.pdf

b. Program or Service Specific Terms

(1) Agency for Health Care Administration (AHCA) - State Medicaid Authority and the lead agency for the Preadmission Screening and Resident Review (PASRR) process in the state.

(2) Appeals and Fair Hearing Process – The procedure that allows an individual or his/her representative to appeal an adverse PASRR decision to a higher authority. The fair hearing is conducted by a hearings officer from the Department's Inspector General's Office in accordance with the Rule 65-2.042, Florida Administrative Code (F.A.C.).

(3) Children's Multidisciplinary Assessment Team (CMAT) - A Department of Health team that assesses Children who have serious medical care needs.

(4) Comprehensive Assessment and Review for Long-Term Care Services (CARES) – A federally mandated pre-admission screening program for nursing home applicants conducted by the Department of Elder Affairs.

(5) Olmstead Decision – The United States Supreme Court ruling in Olmstead v. L.C. (1999) that the unnecessary segregation of individuals with disabilities in institutions may constitute discrimination based on disability. The court ruled that the Americans with Disabilities (ADA) Act may require states to provide community-based services rather than institutional placements for individuals with disabilities.

(6) Plan of Care – A treatment plan for specialized services.

(7) Preadmission Screening (PAS) – The process of screening and evaluating persons with possible mental illness who are being considered for admission to a nursing facility. This includes the Level I screening and, if needed, the Level II evaluation and determination of the need for specialized services.

(8) Preadmission Screening and Resident Review (PASRR) Level I – The initial screening required for all individuals prior to admission to a Medicaid certified nursing facility, regardless of payer source. The screening is conducted by hospitals, CMAT, or CARES for preadmission screenings.

(9) Preadmission Screening and Resident Review (PASRR) Level II – A comprehensive evaluation that is required for all individuals identified in the Level I screening as having possible serious mental illness. The evaluation is the responsibility of the SMHA. The Level II evaluation and determination must verify a diagnosis of serious mental illness, determine if the individual requires the level of services provided by a nursing facility and determine whether or not the individual needs specialized services. If Specialized Services are needed,
the Level II evaluator must complete a plan of care and arrange for the provision of services to be provided and monitor the provision of these services. CARES or CMAT submits requests for Level II’s for clients in the community or hospital settings.

(10) **Preadmission Screening Face-to-Face Review** – A face-to-face evaluation of an individual prior to admission to a nursing facility to confirm the presence of a mental illness that cannot be clearly determined by a record review. If the individual is determined to have serious mental illness, the face-to-face evaluation will confirm the need for the level of services provided in a nursing facility and if specialized services are needed.

(11) **Preadmission Screening Record Review** - A detailed review of the individual’s medical record is used to evaluate individuals with possible mental illness prior to admission to a nursing facility and to determine a possible need for specialized services.

(12) **Psychiatric Evaluation** – A psychiatric evaluation is a comprehensive evaluation that investigates the person’s clinical status including the presenting problem; the history of the present illness; previous psychiatric history, physical history, and medication history; relevant personal, and family medical history; personal strengths; and a brief mental status examination. This examination concludes with a summary of findings, diagnostic formulation, and treatment recommendations.

(13) **Resident Review** – The process of evaluating a nursing facility resident with possible mental illness who experiences a significant change in his or her physical or mental condition. The Level I is not re-done for a Resident Review, The Nursing Facility completes or reviews the Minimum Data Set (data system managed by the Agency for Health Care Administration) to determine the need for a Resident Review leading to the completion of an evaluation and determination of the need for specialized services.

(14) **Resident Review Face-to-Face Review** – A face-to-face evaluation of a nursing facility resident to evaluate identified changes in mental status to determine the need for specialized services that cannot be clearly determined by a record review.

(15) **Resident’s Record Review** – A detailed review of a nursing home resident’s medical record is used to evaluate identified changes in mental status to determine a possible need for specialized services.

(16) **Serious Mental Illness (SMI)** – An individual is considered to have a serious mental illness if the individual meets the requirements in 42 CFR 483.102(b)(2) based on diagnosis, level of impairment, and duration of illness.

(17) **Service Providers** – Local agencies providing substance abuse and mental health services that are under contract with the Department.

(18) **Specialized Services for Serious Mental Illness** - Specialized services are services not covered in the nursing facility per diem, but are provided within the nursing facility. For individuals determined to have serious mental illness, specialized services within the PASRR context are services utilized to address an episode of mental illness and are rendered at levels required to avert or eliminate the need for acute inpatient psychiatric care. Specialized services
are developed and supervised by a qualified mental health professional and include one or all of the following: psychiatric consultation and evaluation, psychotropic medication management, psychological evaluation, and/or psychotherapy. PASRR Level II evaluations and determinations include a written plan of care when specialized services are needed and ensure that individuals requiring specialized services receive those services. Compensation of services rendered will occur through the applicant’s or resident’s availability of benefits, such as Medicare, Medicaid or private insurance. Such services for indigent individuals without other healthcare benefits will be arranged by the mental health program offices within the region that the services are provided.

(19) Specialized Services Referral Process – Part of the PASRR Level II determination process which provides for a written plan of care for specialized services and ensures that individuals requiring specialized services receive those services pursuant to written policies and procedures.

2. General Description

a. General Statement. Preadmission Screening and Resident Review (PASRR) is a federal requirement mandated by the Nursing Home Reform Act, under the Omnibus Budget Reconciliation Act of 1987, amended in 1990 and 1996. The program is intended to prevent the inappropriate placement and retention of individuals with mental illnesses in nursing facilities and supports the Olmstead Act. The PASRR process consists of two parts: Level I and Level II.

(1) Level I screenings are required:

a. Before a person can be admitted to a nursing facility, a Level I screening must be completed by either Florida Comprehensive Assessment and Review for Long-Term Care Services (CARES) within the Department of Elder Affairs, or Children’s Multidisciplinary Assessment Treatment (CMAT) within the Department of Health. This is considered a preadmission screening (PAS).

b. After a person has been admitted to a nursing facility, if there is a significant change. The Nursing Facility uses the Agency for Health Care Administration’s (AHCA) Minimum Data Set system to initiate a referral for evaluation and determination from the SMHA or their designee. This is considered a Resident Review.

(1) Level II evaluations are required for any referrals that are received from CARES or CMAT as a result of Level I screenings. As the State Mental Health Authority (SMHA), the Department of Children and Families' Mental Health Program Office is responsible for Level II evaluations for persons with mental illnesses. Through this contract, the Provider shall perform these duties and responsibilities: receive referrals; evaluate the referrals by means of a record review or face-to-face evaluation; conduct a Psychiatric Evaluation, if needed; determine and arrange for specialized services if needed; send required notices; track all referrals; and submit reports to the Department regarding actions taken.

b. Authority. The Department’s authority for contracting for the provision of these services is stated in Chapter 394.457(3), Florida Statutes. The state is mandated to
provide for PASRR to comply with federal regulations: Sections 1919(b)(3)(F) and 1919(e)(7) of the Social Security Act and 42 CFR 483.100-.138, Subpart C.

c. **Scope of Services.** The Provider shall design, implement and operate the State of Florida’s Mental Health PASRR Level II Evaluation process, and arrange or coordinate any specialized services recommended as a result of the PASRR Level II evaluation process. The Provider shall provide technical assistance and training to nursing facilities and service providers as requested by the Department. The Provider shall perform all required services under this contract, subject to the provisions contained herein and in compliance with Chapter 394, F.S. and 42 CFR 483, Subpart C.

d. **Major Program Goals.** The major program goals are to implement and operate a standardized approach to PASRR Level II evaluations and Resident Reviews to prevent the inappropriate placement and retention of individuals with SMI in nursing facilities and to address the need for specialized services including determining who will be providing those services and the approximate duration those services will be needed.

3. **Clients to be Served**
   a. **Eligibility.** The Provider shall serve any individuals who have been referred for a PASRR Level II evaluation/Resident Review by CARES, CMAT, and nursing facilities.
   b. **Service Determination.** The Provider shall accept and review all referrals for a PASRR Level II evaluation/Resident Review.
   c. **Contract Limits.** The Provider shall serve only individuals who have been referred for PASRR Level II or Resident Reviews from CARES, CMAT, and nursing facilities.

B. **Manner of Service Provision**

1. **Project Timeline**
   a. The Provider shall continue the state of Florida’s current Mental Health PASRR Level II process immediately upon the date of contract execution (Start-up Phase).
   b. The Provider shall design an automated PASRR Level II process to be implemented by July 1, 2014 (Design Phase).
   c. The Provider shall implement and continue to operate the automated PASRR level II process during the remainder of the contract period (Implementation Phase).

2. **Service Tasks**
   a. **Task List**
      (1) **START-UP Phase (July 1, 2013 – March 31, 2014)**
         a. The Provider shall implement the following existing written policies and procedures for the overall PASRR Level II Process which may be located at _________________ and are hereby incorporated:
            a. PAS Record Reviews;
            b. PAS Face-to-Face Reviews;
            c. Resident Record Review;
            d. Face-to-Face Resident Reviews; and
(b) The Provider shall conduct and complete all Level II evaluations within nine (9) days of receipt of any complete referral from CARES or nursing facilities.

(c) Referral Documentation. The Provider shall complete and maintain the following documents located at ________ for all Level II reviews and Resident Reviews:

1) PASRR-MI Level II Referral Packet Checklist
2) HIPAA form
3) Informed Consent
4) Request For Level II PASRR Evaluation and Determination – AHCA form 004, Part B
5) Level I PASRR Screen – AHCA form 004, Part A
6) Patient Transfer/Continuity of Care form 3008
7) Psychiatric Assessment (Optional) – DOEAMH form 1911A
8) Psychiatric Assessment – DOEAMH form 1911B

(d) The Provider shall ensure that all Psychiatric Assessments are adapted to the cultural background, language, ethnic origin and means of communication used by the individual being evaluated.

(e) Specialized Services Referral Process

1) The Provider shall ensure that individuals requiring Specialized Services receive those services pursuant to written policies and procedures.
2) The Provider shall track the ongoing monitoring of the Specialized Services provided, the duration, and the outcome.

(f) Appeals and Fair Hearings Process

1) The Provider shall re-review any PASRR Level II determination in which an appeal for a fair hearing is made to the Inspector General’s Office regarding an adverse determination.
2) The Provider shall participate in a scheduled fair hearing by timely submitting any required documentation and shall provide expert testimony via telephone at the actual hearing if necessary.

(g) Quality Assurance and Management Process

1) The Provider shall implement a Quality Assurance and Management Plan and written policies and procedures that ensure ongoing quality assurance (QA) and quality improvement (QI) activities.
2) The Provider shall ensure that Quality Assurance and Management include clinical training (including physician oversight); frequency and type of supervision; timeliness related to PASRR performance requirements; and peer review.
(h) **Data System**

1) The Provider shall implement and maintain a data tracking system that captures, stores, and organizes documents and program information. This technology must leverage high-volume fax servers equipped to receive faxes from all fax machines fully compliant with the international Group 3 Facsimile transmission standards, from legacy manual machines through the latest PC based systems. If a fax transmission should fail or terminate early, the sender must receive the error report their system provides for any failed fax transmission.

2) The Provider shall ensure that the data system tracks referrals and all data elements identified in (3)(j) below.

3) The Provider shall ensure that, once received, faxes associated with cases in the database are stored as a care record in a unique folder. This folder shall be used to file all medical records received during the term of the contract, and all portions of the PASRR evaluation.

4) The Provider shall ensure security and confidentiality of data in compliance with applicable federal and state laws (including HIPAA Privacy Rules, 45 C.F.R. Parts 160 and 164). This includes fax receipt, data transmission, data storage, and data retrieval systems will meet all federal and state laws for security and confidentiality of data in effect at the time the system is implemented.

(2) **DESIGN PHASE-Automation (to be completed by June 30, 2014)**

(a) The Provider shall develop an automated on-line process to implement and operate the PASRR Level II process. This process shall include an online referral form that allows the CARES, CMAT, and nursing facilities to submit referrals and all documents for Level II and Resident Reviews on-line through a secure website in lieu of faxing documents.

(b) The Provider shall update and implement the following written policies and procedures necessary to perform the tasks outlined in the Implementation Phase:

1) Stakeholder Relations Process
2) PASRR Evaluation Level II Process
3) PAS Record Review Process including administrative closure criteria and process to avert such closures
4) PAS Face-to-Face Review Process
5) Resident Record Review Process
6) Resident Face-to-Face Review Process
7) Specialized Services Referral Process
8) Education and Training Process
9) Quality Assurance and Management Process
10) Appeals and Fair Hearings Process
11) Electronic Data Collection and Tracking Process

(3) IMPLEMENTATION PHASE (July 1, 2014 through the remainder of the contract)

(a) The Provider shall implement the automated referral process that allows CARES and CMAT to submit referrals for Level II and nursing facilities to submit Resident Reviews on-line through a secure website.

(b) The Provider shall implement a website that describes the PASRR II process, contains all updated forms, the link for the online referral, and contains contact information and other important links that relate to the PASRR process. At a minimum, the website shall include links to AHCA, DOEA, CMAT, and relevant Federal regulations.

(c) Stakeholder Relations

1) The Provider shall implement the Stakeholder Relations written policies and procedures.

2) The Provider shall conduct and facilitate routine stakeholder meetings, as mutually determined by the Department and the Provider.

3) The Provider shall collaborate with the Department, CARES, CMAT, and AHCA in designing the PASRR system components for the SMHA.

4) The Provider shall establish a collaborative relationship with the CARES and CMAT units throughout the state.

(d) PASRR Level II/Resident Review Process. The Provider shall implement the updated written policies and procedures for the overall PASRR Level II Process including:

1) conducting and completing all Level II evaluations within nine (9) business days of receipt of any completed referral from CARES or nursing facilities;

2) conducting and completing all Level II evaluations within four (4) business days of receipt of any completed referrals from CMAT;

3) ensuring all evaluations are adapted to the cultural background, language, ethnic origin and means of communication used by the individual being evaluated;

4) when and how to conduct a PAS Records Review, including administrative closure criteria and process to avert such closures;

5) at a minimum, face-to-face reviews shall be conducted when, after record review, it appears that specialized services should be recommended;

6) when and how to conduct a Resident Record Review;

7) when and how to conduct a Resident Face-to-Face Review;

8) arrangement and coordination of any Specialized Services or services of lesser intensity recommended as a result of the PASRR Level II evaluation;
9) Plans of Care shall include the identification of the needed specialized services, who will provide the services, when the services are to begin, and the approximate duration of those services. Data collected must include disposition:

   a. Does the individual meet the State definition for mental illness
   b. Are Specialized Services needed?
   c. If yes, can these Specialized Services be provided in a nursing facility?
   d. Can Specialized Services be provided in the community?
   e. If so, is nursing facility placement still appropriate?
   f. If Specialized Services are needed, attach the Plan of Care that are required to the PASRR II.
   g. If Specialized Services are not needed, attach other service recommendations required to meet identified needs.

(e) Tracking System. The Provider shall implement a tracking system that will allow quarterly monitoring of the specialized services provided, the duration and the outcome. Additional data elements shall include:

1) Did the individual receive the recommended specialized services.
2) If not, why not?
3) List other specialized services received, if any.
4) Has the individual experienced a psychiatric episode that resulted in hospitalization (Baker Act admission)?
5) If so, did the facility accept the person back after the hospitalization?
6) What is the facility doing to prevent future psychiatric hospitalizations?

(f) Appeals and Fair Hearings Process

1) The Provider shall re-review any PASRR Level II determination in which an appeal for a fair hearing is made to the Inspector General’s Office regarding an adverse determination.
2) The Provider shall participate in a scheduled fair hearing by timely submitting any required documentation and shall provide expert testimony via telephone at the actual hearing if necessary.

(g) Education and Training Plan

1) The Provider shall develop materials for CARES, hospitals and nursing facilities that describe the policies and procedures for the PASRR Level II referral process. These materials shall be distributed electronically and made available on-line.
2) The Provider shall offer at least two semi-annual webinars regarding the Level II process and shall include updated information as appropriate. The webinars shall be recorded and made available free of charge on the both Provider and the Department’s websites.
3) The Provider shall provide periodic phone technical assistance to nursing facility staff throughout the contract period, as needed and requested by the staff of the nursing facilities or as identified by the Provider or Department.

(h) Quality Assurance and Management Process
1) The Provider shall develop and implement a Department approved Quality Assurance and Management Plan and written policies and procedures that ensure ongoing quality assurance (QA) and quality improvement (QI) activities.

2) These activities shall include clinical training including physician oversight; frequency and type of supervision; timeliness related to PASRR performance requirements; and peer review.

(i) Data System
1) The Provider shall implement an electronic database with the capability to track referrals, provide notifications, and dispositions of all referrals, including but not limited to the following:
   a) new admissions to nursing facilities;
   b) residents requiring a resident review or for whom the status of functioning appears to have changed; and
   c) referrals for which clinical record reviews and/or Level II evaluations or Resident Reviews are not completed (e.g., deaths, discharges/transfers from nursing facilities, those never admitted to nursing facilities, those admitted for hospitalizations).

2) The Provider shall maintain an electronic database with the capability to provide data on all Level II referrals, including:
   a) referral source;
   b) referral date;
   c) county code for county of evaluation using the Department’s codes;
   d) individual’s last name, first name, and middle initial;
   e) Social Security number;
   f) Medicaid number;
   g) Medicare number;
   h) date of birth;
   i) gender;
   j) mental illness diagnoses;
   k) current medications;
   l) date of most recent Psychiatric Evaluation;
   m) nursing facility appropriate;
   n) nursing facility not appropriate;
o) services of lesser intensity recommended and what services;

p) specialized services recommended and what services;

q) Baker Act services recommended;

r) administrative closures;

s) reason for administrative closures;

t) date of Plan of Care implementation in facility;

u) date and outcome for nursing facility care;

v) date and outcome for Specialized Services provided as outlined in (3)(e) above;

w) date and outcome for rehabilitative services of a lesser intensity than specialized services provided;

x) date and outcome of face-to-face evaluation;

y) date of determination;

z) date results submitted to originating CARES or CMAT office;

aa) date notice sent to individuals and required persons;

bb) facility location and status of residents requiring a RR;

cc) facility admission date, if admitted or indication of no admission; and

dd) date and outcome of quarterly follow-up request to nursing facilities for those who were admitted to nursing facilities with specialized services recommended.

b. Task Limits. The Provider shall not perform any tasks related to the project other than those described in Attachment I, Section B., without the prior written approval of the Department’s contract manager.

c. Staffing Requirements

(1) Staff Levels. The Provider shall maintain an administrative organizational structure and staff to perform the contractual responsibilities of this contract. In the event the Department determines that the provider’s staffing levels do not conform to those necessary to perform the tasks, the Department will advise the provider in writing and the Provider shall have thirty (30) days to remedy the identified staffing deficiencies.

(2) Professional Qualifications

(a) The Provider shall recruit and retain at least one (1) of each of the following professionals who are licensed in Florida to ensure that minimum requirements for conducting PAS and Resident Reviews for content, timeliness, and signatures are met:

1) registered nurse;

2) licensed psychologist;

3) physician; and
4) mental health professionals (Social Workers, Mental Health Counselors).

The Provider must ensure that it maintains, at all times, the ability to provide evaluations in all counties of the State of Florida.

(b) The Provider shall maintain complete documentation verifying each evaluator’s qualifications and training, including the results of a criminal records check for employees or subcontractors who will have direct contact with nursing facility residents.

c) The Provider staff shall include at least one (1) staff member who is a Florida licensed physician with a minimum of two (2) years of experience with individuals with mental illness. The physician shall perform the Medical Director’s duties. The physician may be a part-time staff member or consultant.

d) The Provider shall ensure that all employees working with the PASRR project meet all licensing requirements for their respective discipline when applicable and pass a Florida Department of Law Enforcement (FDLE) background check; before directly working with individuals for which PASRR screenings and evaluations will be conducted. Results must be received and deemed acceptable prior to direct contact with persons served.

(3) **Staffing Changes.** The Provider shall notify the Department’s contract manager in writing of any key leadership personnel changes within seven (7) calendar days.

(4) **Subcontractors.** The Provider may subcontract for services specified in this contract. All subcontracting is subject to the provisions of Section 7. of the Standard Contract. Subcontracting shall in no way relieve the Provider of any responsibilities for performance of its duties under the terms of this contract.

3. **Service Delivery Location, Service Times, and Equipment**

   a. **Service Delivery Location**

   (1) The Provider shall maintain an administrative (local service center) in Tallahassee, Florida that shall be responsible for receiving all referrals from CARES units and nursing facilities.

   (2) The Provider shall ensure that the service center is operational and available for receiving referrals during regular business hours (8:00 a.m. to 6:00 p.m. EST Monday through Friday, excluding state-observed holidays).

   b. **Service Times.** The Provider shall be available to provide technical assistance, answer questions, and provide training during the Department’s regular business hours (8:00 a.m. to 5:00 p.m. local time in Tallahassee, Florida, Monday through Friday, excluding state-observed holidays).

   c. **Change in Location.** The Provider shall notify the Department’s contract manager in writing a minimum of seven (7) calendar days prior to making a change in location.

   d. **Equipment.** The Provider shall be responsible for supplying, at its own expense, all equipment necessary to perform under this contract including, but not limited to, computers, telephones, copier and fax machine including supplies and maintenance, as well as, needed office supplies.
4. Deliverables

a. Service Units. A unit of service is described in Attachment I, Section C.1. Each unit of service shall be delivered in accordance with the terms and conditions of this contract and performed in a manner acceptable to the Department.

b. Records and Documentation

(1) Where this contract requires the delivery of written policies and procedures to the Department, mere receipt shall not be construed to mean or imply acceptance of those documents. It is specifically intended by both parties that the receipt and acceptance of these documents shall constitute a separate act.

(2) The Department reserves the right to reject any deliverable as incomplete, inadequate or unacceptable according to the parameters set forth in this contract. Each required policy and procedure must be accepted and approved by the Department prior to submission of the invoice payment for the design phase. Each required policy and procedure must be approved by the Department prior to full payment of the invoice.

The Department will not approve incremental payments for the Statewide PASRR Level II Evaluation Process. Each written policy and procedure required under the design phase shall be delivered electronically to the contract manager within the timeframes established in Section B.4.c., of this contract.

c. Reports

(1) The Provider shall submit the reports listed below within the specified time frames to the Department’s contract manager:

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Reporting Frequency</th>
<th>Report Due Date</th>
<th># of Copies Due</th>
<th>Contact Name and Address to Receive Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DRAFT</strong> Statewide Preadmission Screening and Record Review Level II Evaluation Process Policies &amp; Procedures</td>
<td>Once</td>
<td>July 30, 2013</td>
<td>1 hard copy and 1 electronic copy</td>
<td></td>
</tr>
<tr>
<td><strong>FINAL</strong> Statewide Preadmission Screening and Record Review Level II Evaluation Process Policies &amp; Procedures</td>
<td>Once</td>
<td>August 30, 2013</td>
<td>1 hard copy and 1 electronic copy</td>
<td>Contact Manager as listed Section 18.c. of the Standard Contract</td>
</tr>
<tr>
<td><strong>DRAFT</strong> Updated Statewide Preadmission Screening and Record Review Level II Evaluation Process Policies &amp; Procedures</td>
<td>Once</td>
<td>May 30, 2014</td>
<td>1 hard copy and 1 electronic copy</td>
<td></td>
</tr>
<tr>
<td><strong>FINAL</strong> Updated Statewide Preadmission Screening and Record Review Level II Evaluation Process Policies &amp; Procedures</td>
<td>Once</td>
<td>June 30, 2014</td>
<td>1 hard copy and 1 electronic copy</td>
<td></td>
</tr>
</tbody>
</table>
Invoice and the following supporting documentation;
PAS and Resident Record Reviews Report
PAS and Resident Reviews Face-to-Face Reviews Report
Performance Report (as outlined in section below)

<table>
<thead>
<tr>
<th>Reporting Type</th>
<th>Frequency</th>
<th>Due Date Description</th>
<th>Copies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reporting</td>
<td>Monthly</td>
<td>15th of each month following the month of service provision</td>
<td>1 hard copy and 1 electronic copy</td>
</tr>
<tr>
<td>Quarterly Reporting</td>
<td>Quarterly</td>
<td>15th of each month following the quarter of service provision</td>
<td>1 hard copy and 1 electronic copy</td>
</tr>
<tr>
<td>Expenditure Reports</td>
<td>Annually</td>
<td>30 days after the end of each fiscal year</td>
<td>1 hard copy and 1 electronic copy</td>
</tr>
<tr>
<td>Final Expenditure Report</td>
<td>Annually</td>
<td>45 days after the end of the contract</td>
<td>1 hard copy and 1 electronic copy</td>
</tr>
</tbody>
</table>

(2) **PAS and Resident Record Review Report/PAS and Resident Face-to-face Review Report.** In accordance with the above Reports Table, the Provider shall submit a report which includes a spreadsheet listing the following for each person reviewed:

- **last name, first name, middle initial;**
- **birthdate;**
- **social security number;**
- **type of review;**
- **date referral received;**
- **date referral completed;**
- **disposition (nursing facility appropriate, nursing facility not appropriate, list specialized services required, if any);** and
- **number of children under 21 referred.**

(3) **Report of Specialized Services.** For all persons for whom specialized services were recommended during the previous quarter, list in a spreadsheet the following for each person: last name, first name, middle initial; birthdate; social security number; type of initial review; date of initial referral; list specialized services required upon review; name of mental health provider referred to; date of mental health provider referral; outcome of services as reported by nursing facility (including: services provided; dates of services provided; end date of services, if applicable).

(4) **Expenditure Report.** In accordance with the above Reports Table, and in a Department approved format, the Provider shall submit to the Department's
contract manager an annual expenditure report reconciling actual review volume and associated costs versus the amount received from the Department during each fiscal year.

If any of the expenditure reports submitted by the Provider identifies any unearned income, the Provider shall be directed to return funds to the Department within sixty (60) calendar days after the ending of the specific contractual performance period. Any funds identified as unearned income may be repaid by a check from the Provider or the Department’s contract manager shall make deductions from future invoice payment requests until the unearned income has been repaid in full.

(5) Performance Report.

5. Performance Specifications

a. Performance Measures

(1) The Provider shall complete a minimum of 90% of the Level II Determinations for pre-admission screenings within nine (9) business days of receipt of a completed referral from CARES.

(2) The Provider shall complete a minimum of 90% of the Level II Determinations for pre-admission screenings within four (4) business days of receipt of a completed referral from CMAT.

(3) The Provider shall complete a minimum of 90% of the Level II Determinations for resident reviews within nine (9) business days of receipt of a completed referral from nursing facilities.

(4) The Provider shall ensure that no more than 5% of monthly referrals are administratively closed by the Provider.

b. Performance Evaluation Methodology. The Provider shall collect information and submit performance data to the Department’s contract manager.

(1) For Performance Measure (1) the percentage is determined as follows:

\[
\frac{\text{Total number of Level II Determinations for pre-admission screenings completed within nine (9) business days of receipt of a completed referral from CARES.}}{\text{Total number of completed referrals from CARES.}} \geq 90\%
\]

(2) For Performance Measure (2) the percentage is determined as follows:

\[
\frac{\text{Total number of Level II Determinations for pre-admission screenings completed within four (4) business days of receipt of a completed referral from CMAT.}}{\text{Total number of completed referrals from CMAT.}} \geq 90\%
\]
(3) For Performance Measure (3) the percentage is determined as follows:

Total number of Level II Determinations for resident reviews completed within nine (9) days of receipt of a completed referrals from nursing facilities.  ≥ 90%

Total number of completed referrals from nursing facilities.

(4) For Performance Measure (4) the percentage is determined as follows:

Total number of monthly referrals administratively closed by the Provider ≤ 5%

Total number of monthly referrals.

c. By execution of this contract the Provider hereby acknowledges and agrees its performance under the contract must meet the standards set forth above and will be bound by the conditions set forth in this contract. If the Provider fails to meet these standards, the Department, at its exclusive option, may allow a reasonable period, not to exceed six (6) months, for the Provider to correct performance deficiencies. If performance deficiencies are not resolved to the satisfaction of the Department within the prescribed time, and if no extenuating circumstances can be documented by the Provider to the Department’s satisfaction, the Department must terminate the contract. The Department has the sole authority to determine whether there are extenuating or mitigating circumstances. The Department’s contract manager will monitor the standards and outcomes specified in Section B.5., Performance Specifications, during the contract period, to determine if the Provider is achieving the levels that are specified.

6. Provider Responsibilities

a. Provider Unique Activities

(1) The Provider shall be solely responsible for the satisfactory performance of the deliverables described in this contract. By execution of this contract, the Provider recognizes its responsibility for the deliverables and warrants that it has fully informed itself of all relevant factors effecting accomplishment of the deliverables and agrees to be fully accountable for the performance thereof. In addition, the Provider is fully responsible for the performance of all subcontractors.

(2) The Provider shall maintain monthly contact with the contract manager to report on the performance of the contract activities and discuss any difficulties encountered which may inhibit compliance with the terms and conditions of this contract.

(3) The Provider shall comply with all applicable federal laws, state statutes and associated rules as may be promulgated or amended throughout the term of this contract.

(4) If required by 45 CFR Parts 160, 162, and 164, the following provisions shall apply (45 CFR 164.504(e)(2)(ii)):

(a) The Provider hereby agrees not to use or disclose protected health information (PHI) except as permitted or required by this contract, state or federal law.
(b) The Provider agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this contract or applicable law.

(c) The Provider agrees to report to the Department any use or disclosure of the information not provided for by this contract or applicable law.

(d) The Provider hereby assures the Department that if any PHI received from the Department, or received by the provider on the Department’s behalf, is furnished to provider’s subcontractors or agents in the performance of tasks required by this contract, that those subcontractors or agents must first have agreed to the same restrictions and conditions that apply to the provider with respect to such information.

(e) The Provider agrees to make PHI available in accordance with 45 C.F.R. 164.524.

(f) The Provider agrees to make PHI available for amendment and to incorporate any amendments to PHI in accordance with 45 C.F.R. 164.526.

(g) The Provider agrees to make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528.

(h) The Provider agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Department or created or received by the provider on behalf of the Department available for purposes of determining the provider’s compliance with these assurances.

(i) The Provider agrees that at the termination of this contract, if feasible and where not inconsistent with other provisions of the contract concerning record retention, it will return or destroy all PHI received from the Department or received by the provider on behalf of the Department, that the provider still maintains regardless of form. If not feasible, the protections of this contract are hereby extended to that PHI which may then be used only for such purposes as make the return or destruction infeasible.

(j) A violation or breach of any of these assurances shall constitute a material breach of this contract.

b. Coordination with Other Providers/Entities

(1) The Provider agrees to coordinate services with other community organizations and local, state or federal entities as the need is identified by the Department or the Provider.

(2) The Provider agrees that the failure of other providers or entities to perform does not relieve the provider of any accountability for tasks or services that the Provider is obligated to perform pursuant to the contract.

7. Department Responsibilities

a. Department Obligations

(1) The Department will provide a contract manager for any technical assistance that is needed to fulfill the obligations of this contract.

(2) The Department will provide, in writing, feedback on the deliverables within ten (10) working days from receipt. The acceptance of any deliverable will be at the sole discretion of the Department.
(3) All necessary Department policies and procedures providing instructions on documenting payments for reimbursement will be provided by the Department.

b. Department Determinations. The Department has final authority to determine the quality and acceptability of services and reports delivered.

c. Monitoring Requirements. The Provider shall be monitored in accordance with CFOP 75-8.

C. Method of Payment

1. Payment Clause. This is a fixed price (fixed fee) contract. Subject to the availability of funds, the Department will pay the Provider a total of $3,294,823.50 for the delivery of service units provided in accordance with the terms and conditions of this contract, in accordance with the table below:

<table>
<thead>
<tr>
<th>State Fiscal Year</th>
<th>Total Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-2014</td>
<td>$1,098,274.50</td>
</tr>
<tr>
<td>2014-2015</td>
<td>$1,098,274.50</td>
</tr>
<tr>
<td>2015-2016</td>
<td>$1,098,274.50</td>
</tr>
<tr>
<td>Total</td>
<td>$3,294,823.50</td>
</tr>
</tbody>
</table>

2. Deliverables/Payment Schedule. The Provider must submit to the Department’s contract manager all reports required by Section B.4. and the Table of Deliverables/Payment Schedule below for each fiscal year.

a. State Fiscal Year 2013-2014

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Number of Units</th>
<th>Unit Cost</th>
<th>Total Price</th>
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</thead>
<tbody>
<tr>
<td>START-UP/CONTINUATION PHASE (9 month)</td>
<td>9</td>
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<tr>
<td>DESIGN PHASE (3 month)</td>
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<tr>
<td>Statewide PAS Record Review Level II Evaluation Process</td>
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</tr>
<tr>
<td>IMPLEMENTATION PHASE (12 months)</td>
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</tr>
<tr>
<td>Monthly PAS &amp; Resident Review Record Reviews Report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Amount</strong></td>
<td></td>
<td></td>
<td>$1,098,274.50</td>
</tr>
</tbody>
</table>

b. State Fiscal Year 2014-2015

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Number of Units</th>
<th>Unit Cost</th>
<th>Total Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly PAS &amp; RR Record Reviews Report</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly PAS &amp; RR Face-to-Face Reviews Report</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Amount</strong></td>
<td></td>
<td></td>
<td>$1,098,274.50</td>
</tr>
</tbody>
</table>
c. State Fiscal Year 2015-2016

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Number of Units</th>
<th>Unit Cost</th>
<th>Total Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly PAS &amp; RR Record Reviews Report</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly PAS &amp; RR Face-to-Face Reviews Report</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Amount</strong></td>
<td><strong>$1,098,274.50</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Invoice Requirements
   a. The Provider shall request payment through the submission of a properly completed invoice, Exhibit A, and shall be accompanied by the reports and the deliverables due at the time of invoice submission, as outlined Reports Table, section B.4.c.(1).
   b. The contract manager will review the Provider’s invoice and approve or reject the deliverable, and notify the Provider in writing if there are any discrepancies or deficiencies.
   c. The Department will reduce or withhold funds pursuant to Rule 65-29.001, F.A.C., if the provider fails to comply with the terms and conditions of the contract. Approval of payment for services in dispute shall be made upon completion of any required corrective actions. The Department’s decision to reduce or withhold funds shall be submitted to the provider in writing. The written notice shall specify the manner and extent to which the provider has failed to comply with the terms of the contract. When compliance is achieved, withheld funds shall be reinstated to the Provider.
   d. The Provider shall submit the final invoice for payment to the Department for each fiscal year no later than July 15th of each contract year.

D. Special Provisions
   1. MyFloridaMarketPlace Registration. To comply with Rule 60A-1.030, F.A.C., each vendor doing business with the State for the sale of commodities or contractual services as defined in section 287.012, F.S., shall register in the MyFloridaMarketPlace system, unless exempted under Rule 60A-1.030 (3), F.A.C. Information about the registration process is available, and registration may be completed, at the MyFloridaMarketPlace website (link under Business on the State portal at www.myflorida.com).
   2. MyFloridaMarketPlace Transaction Fee
      a. The State of Florida, through the Department of Management Services, has instituted MyFloridaMarketPlace, a statewide eProcurement system. Pursuant to subsection 287.057(23), F.S. (2002), all payments shall be assessed a Transaction Fee of one percent (1.0%), which the provider shall pay to the State.
      b. For payments within the State accounting system (FLAIR or its successor), the Transaction Fee shall, when possible, be automatically deducted from payments to the provider. If automatic deduction is not possible, the provider shall pay the Transaction Fee pursuant to Rule 60A-1.031(2), F.A.C. By submission of these reports and corresponding payments, provider certifies their correctness. All such reports and payments shall be subject to audit by the State or its designee.
      c. The provider shall receive a credit of any Transaction Fee paid by the provider for the purchase of any item(s) if such item(s) are returned to the provider through no
fault, act, or omission of the provider. Notwithstanding the foregoing, a Transaction Fee is non-refundable when an item is rejected or returned, or declined, due to the provider’s failure to perform or comply with specifications or requirements of the agreement.

d. Failure to comply with these requirements shall constitute grounds for declaring the provider in default and recovering procurement costs from the provider in addition to all outstanding fees. PROVIDERS DELINQUENT IN PAYING TRANSACTION FEES MAY BE EXCLUDED FROM CONDUCTING FUTURE BUSINESS WITH THE STATE.

3. **Contract Renewal.** This contract may be renewed for one term not to exceed three (3) years or for the term of the original contract, whichever period is longer. Such renewal shall be made by mutual agreement and shall be contingent upon satisfactory performance evaluations as determined by the Department and shall be subject to the availability of funds. Any renewal shall be in writing and shall be subject to the same terms and conditions as set forth in the initial contract.

4. **Dispute Resolution**

   a. The parties agree to cooperate in resolving any differences in interpreting the contract. Within five (5) working days of the execution of this contract, each party shall designate one person to act as the its representative for dispute resolution purposes, and shall notify the other party of the person’s name and business address and telephone number. Within five (5) working days from delivery to the designated representative of the other party of a written request for dispute resolution, the representatives will conduct a face to face meeting to resolve the disagreement amicably. If the representatives are unable to reach a mutually satisfactory resolution, either representative may request referral of the issue to the Executive Director and the Chief of the Substance Abuse and Mental Health Contract Management of the respective parties. Upon referral to this second step, the Executive Director and the Chief shall confer in an attempt to resolve the issue.

   b. If the Chief and Executive Director are unable to resolve the issue within ten (10) days, the parties’ appointed representatives shall meet within ten (10) working days and select a third representative. These three representatives shall meet within ten (10) working days to seek resolution of the dispute. If the representatives’ good faith efforts to resolve the dispute fail, the representatives shall make written recommendations to the Secretary who will work with both parties to resolve the dispute. The parties reserve all their rights and remedies under Florida law. Venue for any court action will be in Leon County, Florida.

E. **Exhibit:**

   Exhibit A - Fixed Price Invoice Payment Request
EXHIBIT A
FIXED PRICE INVOICE PAYMENT REQUEST
This section to be completed by the Provider

1. Provider's Name: 4. Name of Program:

2. Federal ID Number: 5. Contract Number:

3. Mailing Address for Warrant: 6. Invoice Number:

PART 1 - DELIVERABLES (WORK PRODUCTS)
This section to be completed by the Provider

DESCRIPTION OF REPORTS AND SUPPORTING DOCUMENTATION: AMOUNT REQUESTED:
1. PAS and Resident Review and Records Reviews Data Report $ 
2. PAS and Resident Reviews Face-to-Face Reviews Report $ 
3. Performance Report $ 

TOTAL $ 

DESCRIPTION OF DELIVERABLE(S):
1. 
2. 

I certify the above to be accurate and in agreement with the provider’s records and with the terms and conditions of the contract. Additionally, I certify that all information and support documentation are attached as required by the contract.

Signature__________________________________________ Title__________________________________________ Date______________

PART 2 - FUNDING DETAIL
This section to be completed by the Department’s contract manager

<table>
<thead>
<tr>
<th>Organization Code</th>
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<th>GF</th>
<th>SF</th>
<th>FID</th>
<th>BE</th>
<th>CAT</th>
<th>EO</th>
<th>OCA</th>
<th>OBJECT</th>
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<td>100610</td>
<td>Q2</td>
<td>9QPSR</td>
<td>139940</td>
</tr>
</tbody>
</table>

Amount Approved for Payment $ 

Date Goods or Services Received: Date Invoice Received: Date Approved for Payment:

I certify that this invoice has been reviewed and approved for payment.

Signature of Department Contract Manager__________________________________________