



Policy and Procedure

- Section:** Provider Relations
- Subject:** Contract Compliance
- Policy Number:** PR 001, Contract Accountability Reviews
- Effective Date:** November 1, 2012
- Revision Date:** Original Publication
- Review Date:** Annual
- Policy Statement:** This policy establishes formal direction and procedures for Concordia staff and organizations contracted with the Managing Entity in activities related to conducting reviews of Provider performance.
- Policy:** Contract compliance will be assessed on a continuous basis via the established procedures and standards for all programs and services within the Managing Entity (ME) Provider Network. The Provider Network is funded through State of Florida Department of Children and Families (DCF) funding. Therefore, to ensure adherence to uniform procedures and the delivery of services in accordance with applicable federal and state laws, rules, and regulations; the terms and conditions of the contract; and policies, and procedures established by Concordia Behavioral Health, the Managing Entity, the DCF, Providers will also receive onsite and desk reviews to assess performance and compliance in administrative and programmatic requirements. This will provide reasonable assurance consumers/clients receive appropriate and quality services.

Procedures

I. Responsibilities and Duties

- A. Chief Operating Officer
1. Shall require applicable federal and state laws and rules; Contract terms and conditions; and Managing Entity and Concordia policies and procedures are adhered to and ensure processes are established to effectively assess Provider compliance throughout the term of the Contract.
 2. Shall ensure procedures are established for the continuous compliance, and Contract Accountability Reviews with frequency based on the results of Concordia's Risk Assessment.
 3. Shall ensure a report of Provider performance is provided to the Managing Entity Chief Executive Officer prior to the expiration of a Contract.
 4. Shall ensure the developed of internal controls; staff and Provider training; and instruments to effectively and efficiently conduct compliance activities.
 5. Shall ensure an Annual Compliance Review Schedule is developed and adhered to.
- B. Director of Provider Relations
1. Shall develop policies and procedures, instruments, and protocols to ensure Provider compliance, and ensure training is delivered to staff prior to conducting compliance activities to ensure consistency across the Provider Network.

2. Shall serve as a liaison between the Provider Relations Specialist and providers in resolving concerns related to compliance activities.
 3. Shall develop and approve a standardized risk assessment methodology for determining the order and frequency of assessing compliance.
 4. Shall ensure a Contract Accountability Review Report is developed and forwarded to the Provider no more than thirty (30) calendar days after the completion of the Review (date of the Exit Conference/completion of review of limited scope items).
 5. Shall review Contract Accountability Review reports and provide direction to staff in conducting reviews; preparing reports; and reviewing outcome-based corrective action plans (CAP).
 6. Shall ensure the development, approval, and adherence to an annual Compliance Review Schedule for the Provider Network and procedures to ensure each Provider receives the same notification of a visit.
 7. Shall prepare a monthly report of compliance activities to the Managing Entity Chief Executive Officer that includes the number of reviews; key concerns; status; and follow up activities.
 8. Shall ensure the completion of an annual Risk Assessment and review a sample to ensure accuracy and inter-rater reliability.
 9. Shall provide training to staff in compliance review policies; procedures; instruments; and applicable federal and state laws, rules, and regulations prior to staff participation in compliance review activities.
 10. Shall conduct quarterly file reviews of the Contract Manager file to ensure the inclusion of compliance reports; instruments; CAP; and Review notes.
 11. Shall provide immediate notification to the Chief Operating Officer and the Managing Entity Chief Executive Officer when the following situations are identified:
 - a. A deficiency adversely impacts the safety and/or security of the client; staff; and/or the public; and/or
 - b. A deficiency adversely impacts the Provider's ability to provide quality services as required by the Contract; and/or
 - c. The Provider fails to submit and successfully implement corrective actions to address each identified deficiency within the required timeframes; and/or
 - d. The Provider is recommended for Contract termination or Cure Notice.
 12. Shall ensure approved CAP are outcome-based; include measureable goals; identify the responsible party and date(s) for completion; and address the identified deficiency.
 13. Shall partner with the Director of Quality and Utilization Management; the Invoice Billing Unit; and other departments within Concordia when a Contract Accountability Review requires additional subject matter expertise.
- C. Provider Relations Specialist
1. Shall provide continuous oversight of Provider compliance and Contract Accountability Reviews of Provider performance to ensure compliance with the terms and conditions of the Contract and applicable federal and state laws, rules, and regulations, and policies and procedures.
 2. Shall serve as a liaison with the Provider in achieving compliance and provide entry-level direction to providers on general contract and compliance matters.
 3. Shall establish and maintain a Contract Manager file that includes all documents prepared and obtained as a result of a Contract Accountability Review. HIPAA protected and other confidential information shall be redacted to protect the client and/or staff member's identity. (Note: The FINAL Report



will be maintained in the Provider file; working papers should be contained in a separate working file.)

4. Shall maintain contact with Providers on a regular basis to promote effective information sharing and sufficient oversight to ascertain compliance with all applicable laws, rules, policies, procedures, and the terms and conditions of the Contract.
 5. Shall partner with the Invoice Billing Unit to ensure it is aware of outstanding deficiencies and/or CAP where the Provider has been advised its failure to comply may result in non-payment until such time the outstanding deficiency is corrected or a CAP is implemented.
 6. Shall complete a Risk Assessment for each contract each year prior to July 31 and develop a schedule for compliance reviews for each of his/her assigned contracts that is based on the results of the Risk Assessment.
 7. Shall offer recommendations to the Director of Provider Relations in the manner of the Review and conduct Contract Accountability Reviews, Verification Site Visits, and other reviews related to compliance.
 8. Shall develop a Contract Accountability Review Report and forward to the Director of Provider Relations for review and approval within thirty (30) calendar days of the Exit Interview (onsite) or review of limited scope desk review information.
 9. Shall collaborate with Concordia staff to review and assess the effectiveness of Provider developed CAP.
 10. Shall provide a monthly report of compliance activities that includes the number of Reviews completed; number of deficiencies; efforts to engage other Concordia staff; and outstanding deficiencies and efforts to bring the Provider to compliance and competency.
 11. Shall provide immediate notification to the Director of Provider Relations when any of the following situations are identified:
 - a. A deficiency adversely impacts the safety and/or security of the client; staff; and/or the public; and/or
 - b. A deficiency adversely impacts the Provider's ability to provide quality services as required by the Contract; and/or
 - c. The Provider fails to submit and successfully implement corrective actions to address each identified deficiency within the required timeframes; and/or
 - d. The Provider is recommended for Contract termination or Cure Notice.
- D. Invoice Billing Unit
1. Shall audit invoices to ensure services are accurately represented.
 2. Shall maintain a file for paid invoices and other billing records.
 3. Shall provide technical assistance to the Provider Relations Specialist in the completion of invoices; accessing and utilizing the Concordia Billing Application; and the review of the monthly financial reports.
- E. Subcontracted Providers (Provider Network)
1. Shall maintain Contract compliance throughout the term of the Contract.
 2. Shall submit properly prepared and accurate invoices; reports; service data; and requested documentation to support Concordia's efforts to ensure continuous compliance.
 3. Shall provide quality services consistent with applicable federal and state laws, rules, and regulations; policies and procedures; and the terms and conditions of the Contract.



4. Shall cooperate with Concordia in all Contract Accountability Review procedures. Failure to participate as required by Contract may result in Contract termination.

II. Standards and Processes

A. Risk Assessment

1. Purpose - To describe the process used to prioritize Contract Accountability Reviews through the assessment of risk associated with each contract. Adherence to an established and uniform process advances the efficient application of resources to the areas of greatest need. By efficiently and effectively allocating such resources, assurances can be provided that public safety, public funds, and health care services are assessed without unduly burdening providers and advances the goal activities are performed in an environment free of bias and favoritism in the order and/or frequency providers are reviewed for compliance. The frequency and order of the Accountability Review is based on pre-established factors to rank each contract.
2. Need for Prioritization - An element of risk is always present when contracting public funds to provide services to its clients. Because public funds are used and a vulnerable population served there is deliberate evaluation of risks associated with each contract.
3. Criteria - During the fiscal year 12/13 and 13/14, the following risk criteria are used to identify the risk each contract presents. Subsequently, this will dictate how, when, and who conducts compliance activities will be conducted. The following factors, at a minimum, will be considered in assigning risk:
 - Type of Service(s)
 - Annual Dollar Amount of the Contract or unusually complex matching/funding requirements
 - Pattern of Incidents reported through IRAS
 - Prior Performance on Contract
 - A Qualified, Adverse, or Disclaimed Audit Opinion or no audit
 - Subcontracted Provider has level than two (2) years experience contracting for the similar services with DCF
 - Staffing Issues
 - Concerns reported via other funders, licensing authority, or accreditation
 - Subcontracted Provider does not deliver an evidence-based practice
 - Pattern of failure to meet contract requirements identified through previous compliance review activities or adherence to reporting requirements.
4. Assigning Weight to Factors - Beginning in fiscal year 14/15, weights will be assigned to each factors contained in the Risk Assessment instrument.
 - a. Weight Within Factors - A scale of weights for each of the variables within the factors will be determined. The highest risk variable receives the greatest weight.
 - b. Weight Amongst Factors - In developing the risk levels for the contract, the factors must be ranked with respect to each other. This ranking and weighting of the risk factors assumes that certain factors are more important than others in establishing the level of contract Review for each contract/Provider.

5. Outcome of the Assessment - The assessment will be completed within the first thirty (30) calendar days of the fiscal year. At the conclusion of the assessment process, all contracts will be assigned a relative rating. This information will be used for the purpose of prioritizing activities as captured in an annual Compliance Review Schedule.
 6. Use of Assessment Results - The assessment results will be used to determine the order and/or intensity (frequency and scope) of the Contract Accountability Review. For both administrative and programmatic reviews, the assessment results will be the primary factor considered in the scheduling process; however, the age of the contract (newly executed or approaching renewal, expiration, or termination) will also be considered. When possible, the annual Contract Accountability Review schedule will be coordinated with other reviews or monitoring activities conducted by other funders, accreditation, and Quality and Utilization Management activities, when applicable.
 7. Updating the Assessment - The purpose of the Risk Assessment is to assess risk on an annual basis for the purposes of prioritization. It is designed to be an annual, static depiction of the risk associated with the contract. Thus, the annual assessment will not be updated or revised during the year (i.e., risk scores will not change during the fiscal year). As new contracts are executed during the year, those contracts will be assessed for risk during the next annual Risk Assessment. Additional assessment activities, reviews, and scheduling activities may be conducted as deemed necessary.
- B. Deficiencies and Non-Compliance
1. Purpose - The purpose is to describe the progressive process to notify providers of deficiencies or items of non-compliance associated with performance; to initiate necessary actions to remedy non-compliance items; and to follow-up to ensure full contract compliance. The progressive process includes the following levels of action:
 - LEVEL 1 – Contract Accountability Review (Onsite/Desk Review)
 - LEVEL 2 – Review of the Corrective Action Plan (CAP)
 - LEVEL 3 – Verification Site Visit
 - LEVEL 4 – Meeting with Provider
 - LEVEL 5 – Imposition of Consequences for Non-Compliance.
 - LEVEL 6 – Cure Letter, notifying the Provider of immediate demand for correction
 - LEVEL 7 – Suspension of Services/Termination of Contract.
 2. Process - Whether a deficiency is identified as part of daily contract management, a Contract Accountability Review, or other review (e.g., Quality, Incident), a progressive process to achieve successful correction of each deficiency will be utilized. Providers will be furnished with a written report of deficiencies when identified. The Report will include the deficiency and the timeframe for correction by a Provider. An outcome-based Corrective Action Plan (CAP) must be submitted by the Provider to the Provider Relations Specialist, who will assess its likelihood in successfully addressing the deficiency. A subsequent Verification Site Visit will be conducted to assess the successful implementation of the CAP or in some cases the review the progress of the CAP. In the event a Provider's invoice is reduced for non-delivery of services, the Provider will not be assessed an additional financial consequence for contract non-compliance as defined in this section as the financial consequence would be considered a duplicate action for the same

deficiency. When a Provider has not successfully corrected the deficiency, a face-to-face meeting with the Provider's Chief Executive Officer/Executive Director/President will be conducted to advise the Provider of the findings, the expectations related to correction of the deficiency, and the progressive steps to be taken in the event the Provider fails to successfully address the concerns within the given timeframe(s).

3. Contract Accountability Review - Continuous oversight of Provider compliance will be achieved, in part, through contract management; review of financial reports developed by Concordia's Invoice Billing Unit; and through consideration of monitoring reports prepared by other funding sources, and financial reports prepared by auditors. After the completion of a Risk Assessment, the Provider Relations Specialist will develop a Review Plan that details the manner, frequency, and scope of the Contract Accountability Review. At a minimum, an annual desk review of all contracts will be conducted. The assessment uses pre-determined risk elements to identify which contracts present the greatest risk in the protection of consumers and public funds, and in adhering to the statutory requirements. The Provider Relations Specialist is responsible for scheduling the date of the Review, and identifying other members of a Review Team (when appropriate). The size and the selection of team members is dependent upon the service(s) provided, number of slots, and value of the contract. The goal is to conduct a thorough Review while minimizing disruption to Provider operations, whenever possible. During a site visit, staff may review Administrative and Programmatic items; applicable federal and state laws; and rules, policies, and procedures. Programmatic reviews for medical, mental health, and substance abuse services should always be conducted onsite. Administrative items include a review of Provider financial records (expenditure reports, funding, invoicing); property inventory/inspection; personnel records (background screening, federal and state law compliance); and operations (policies, procedures, manuals, practices). The Programmatic review items relate to the specific services delivered as detailed in the contract. At the completion of an onsite Review, an Exit Conference is conducted between the Review Team and the Provider. The purpose is to review preliminary findings and afford the Provider an opportunity to respond to preliminary findings and/or potential deficiencies by furnishing additional information or supporting documentation. The Exit Conference is a Provider's opportunity to discuss the findings prior to their inclusion in the Contract Accountability Review Report.

Following the completion of a Review a Report is sent to the Provider detailing the findings, participants, methodology, and actions to be taken as a result of the findings. The Report is sent to the Provider within thirty (30) calendar days from the date of the Exit Conference/completion of the Review. The Provider has thirty (30) calendar days, unless otherwise specified, to respond to the findings detailed in the Report. An electronic copy of the Report is will maintained electronically and available to the Managing Entity within three (3) business days of approval of the Report.

4. Corrective Action Plan (CAP) - The Provider is required to develop and implement an outcome-based Corrective Action Plan (CAP), using the approved format to correct each deficiency identified. When a CAP is required, the CAP must be submitted within thirty (30) calendar days of the date of the Contract Accountability Review Report cover letter, unless otherwise stated in the Report. The benefits of an outcome-based CAP

include: 1) the identification of the root cause which led to the deficiency; 2) corrective action steps; 3) short-, mid-, and long-term benchmarks to measure the completion of the corrective actions and allow for ongoing assessment and analysis of the effectiveness of the CAP; and 4) the identification of staff responsible for the implementation of the outcome-based CAP. After the outcome-based CAP is developed by the Provider and reviewed by the Provider Relations Specialist to determine the likelihood of responsiveness. The Provider Relations Specialist may provide technical assistance, if requested by the Provider, including the sharing of best practices, or guidance in how to develop an outcome-based CAP; however, the CAP is developed by the Provider. Once the CAP is received, a Verification Site Visit (Level 3) will be conducted.

5. Verification Site Visit - After receipt of a Provider's CAP and after the anticipated verification date outlined in the CAP, the onsite Site Verification is scheduled, to assess the effectiveness of the provider in correcting each identified deficiency. Verification Site Visits are short in duration and are specific to each deficiency and the corresponding CAP. After the verification visit, if all deficiencies are not corrected, a meeting will be conducted with the Provider's senior leadership.
6. Meeting with the Provider - If the Provider fails to submit a CAP within thirty (30) calendar days of the receipt of the Report, or fails to implement the CAP for identified deficiencies within the specified time frame; and/or fails to make acceptable progress in correcting deficiencies as outlined in the CAP within specified timeframes, additional sanctions may be imposed including financial penalties. Prior to additional sanctions, the Director of Provider Relations will meet with the Provider's Chief Executive Officer/Executive Director/President to advise the Provider of the findings; the expectations related to correction of the deficiency(ies); and the possibility of imposition of additional consequences, including financial consequences. Such meetings must occur within ten (10) business days of completion of a Verification Site Visit.
7. Consequences for Noncompliance - If the Provider fails to submit and implement corrective actions to successfully address the identified findings, a written recommendation will be forwarded to the Managing Entity Chief Executive Officer to outline additional consequences that may be imposed. Such consequences will have been addressed with the Provider in a face-to-face meeting and detailed in a follow up letter to the Provider's Chief Executive Officer/Executive Director/President. After concurrence by the Managing Entity, additional consequences may be assessed. When assessing financial consequences, a consequence will be assessed for each deficiency each day the Provider has failed and continues to fail to address the deficiency(ies). The Provider will be notified of the additional consequence(s), via a Cure Letter that details the steps the Provider must take to resolve the matter, the timeframes to respond, and the additional steps to be taken if the Provider fails to successfully address the matter. Financial consequences will be assessed against the Provider's next invoice. The formula will be determined in consultation with the Managing Entity's Chief Executive Officer.
8. Cure Process/Suspension of Services and/or Contract Termination - The Cure Letter is the final step in the progressive process to work with providers to ensure the delivery of services consistent with the terms of the Contract, and applicable federal and state laws, rules, and regulations. If a deficiency is not successfully corrected within the timeframes provided in the Cure Notice,

services may be suspended or the Contract terminated. A Cure Letter may be issued at any time when a Provider has failed to respond to and correct deficiencies; when non-compliance may cause harm to consumers, staff and/or the public; when there is suspected misuse of public funds; or when non-compliance directly affects the delivery of services to consumers as required by the contract. The Cure Letter advised the continued failure to correct the noted deficiencies within the specified time frame will result in suspension of services and/or termination.

C. Administrative Compliance

1. Purpose - To assess the Provider adherence to general contract terms not related to direct service delivery to clients, and to ensure, in part, against misuse of public funds as contractually agreed.
2. Definition - Administrative compliance is determined through an annual review of Provider compliance with the general terms and conditions of the Contract incidental to consumer services. This includes the review of financial reporting packages, financial management practices, Provider policies and procedures, and personnel training, licensing, and screening. A Review is conducted to determine satisfactory performance and delivery of service prior to Contract renewal.
3. Goal - To promote accountability, satisfactory performance and service delivery consistent with applicable state and federal laws, rules and regulations, policies and the terms and conditions of each Contract. Conducting oversight activities allows for improve delivery of quality services.
4. Process - All contracts are subject to continuous oversight of administrative compliance. This may be accomplished via an onsite Contract Accountability Review; analysis of Provider performance in submitting properly completed invoices, billing patterns, invoice validation, and financial reports; review of accreditation; and/or monitoring reports prepared by other funding sources. These activities may be conducted by the Provider Relations Specialist; the Invoice Billing Unit; the Credentialing Department and the outcomes included in a Contract Accountability Review Report prepared by the Provider Relations Specialist. Many elements of the Administrative review cross multiple contracts, therefore, when a Provider has more than one (1) contract, one (1) coordinated administrative review per Provider will be conducted. Providers are advised reviews can occur at any time with or without notice.
5. Key Players - The Provider Relations Specialist is responsible for enforcing the compliance with contract terms and conditions and collaborates with Quality, Credentialing, Financial and other subject matter experts.
6. Preparing for the Site Visit - When the administrative and programmatic reviews are conducted together, preparing for the onsite visit involves communication with individuals, which may include the Provider's clinical and contractual contacts; a review of the contract and associated attachments, exhibits, the contract manager's file, applicable state and federal laws, rules and regulations, including documents prepared by the Department of Financial Services and the Auditor General; and completion of pre-site activities such as analysis of information in the Provider Portal, SAMHIS, IRAS, Quality Assurance reports and federal, state, regional and local entities which have recently assessed the Provider's business or service delivery practices; and evaluate Desk Review documents provided in advance of the onsite activity. It is critical all staff participating in the Review, are familiar with the contract and relevant documents prior to the Site Visit. A comprehensive preparation enables the Team to engage professionals of other disciplines in the Review

as warranted and may reduce the duration of the onsite visit. While an efficient process is desirable, the primary goal is to conduct a thorough and valuable review of the provider's compliance with the contract.

7. Administrative Compliance Site Visit - Elements of the Administrative Review, include determination of the appropriateness and allowable use of funds; verification of payments; compliance with federal and state audit requirements; assessment of insurance to ensure equipment and property is adequately protected; and adherence to federal and state laws. The duration of the site visit, number of participants, and the frequency and/or timing of the site visit is based on the Risk Assessment score, prior performance, and available staff resources. To ensure consistent and fair practices, all providers shall receive fourteen (14) calendar days written notice of the date of the site visit. The Schedule remains confidential to ensure providers receive the same amount of notification and are not scheduled in consultation with the Provider.
- D. Methods and Tools - The quality and adequacy of services delivered by each Provider is determined, in part, through a review of records, observations of staff participating in a Review, and interviews with consumers and Provider staff. Obtaining a variety of information from all three (3) methods allows for identification of findings that support one another. In a comprehensive Review, each of the following methods will be used, however depending on the scope and/or purpose of the Review, the Provider Relations Specialist may determine conclusions are supported and valid using less than the three methods. Information is analyzed by the Provider Relations Specialist and recorded on tools.
1. Records Review - In some projects, determining programmatic and administrative compliance may call for review of the same records to assess compliance with different terms and conditions of the Contract. The Provider Relations Specialist should avoid duplicative reviews whenever possible. Records review may be conducted in advance of a Site Visit. In some instances, the review may be satisfactory and a Site Visit will not be deemed necessary.
 - a. Surveys, Treatment and Activity Records, and Interview Records: These records verify correct invoices; verification through a review of programmatic records, the services have actually been delivered; eligibility of clients served; and with applicable Florida Administrative Code provisions and the Florida Statutes.
 - b. Personnel Records, Payroll Records, and Organization Charts: The Provider's administrative policies and records to determine contract compliance. These records are also reviewed to assure the Provider has an adequate number of appropriately trained and/or credentialed staff as required by the Contract.
 - c. Invoices and Supporting Documentation - Used to verify expenditures have been made in adherence to the approved budget, the Contract, and applicable federal and state laws, rules and regulations. The same records may be reviewed to verify the contractual terms for services to clients have been met during the Programmatic Review.
 2. Interviews - The interview technique is a systematic collection of verbal information. Prepared questions, asked by the interviewer, are designed to gather basic information about the selected individuals' opinions and attitudes. The answers are either written or recorded. Interviews may be conducted on site. Interviews will be held in a location that allows for privacy whenever possible. Separate interview questions should be developed for each group of

staff board members, clients and their families or guardians. All respondents in each category shall be asked the same set of questions in order to assure comparability of responses and to reduce bias. Questions should be commensurate with staff's training, licensure, and area of expertise. A random sample of persons to be interviewed is selected.

3. Observations and Tools - Administrative Review Instrument is utilized. Observation and/or interviews are used as the primary techniques only when a document is not available for review. The observation and interview techniques are often used in combination with other data collection methods.
- E. Entrance Conference at the Provider Site - The Provider Relations Specialist conducts an entrance conference with the Provider's official representatives, as designated by the Provider. The Provider is informed of the purpose, scope and schedule of the site visit. Documents submitted prior to the site visit are also considered.
- F. Review Requirements – Assessing compliance is intended to provide information to ensure the Contract terms and conditions are satisfactorily met. Key questions to be answered include whether the Provider's administrative systems are adequate to manage the contracted funds; whether the Provider is delivering services according to contract terms and conditions; and whether the Provider's data collection, recording, and reporting process is valid.
 1. Invoices and payments are reviewed to ensure the contract terms and conditions have been satisfactorily met. Any financial irregularities shall be addressed, including a review of the Provider's financial system, when warranted.
 2. If an audit is not available the review shall be conducted in consultation with the Invoice Processing Unit and/or the ME financial representatives. An unqualified audit opinion letter resulting from a financial review performed by an independent CPA firm can justify reliance on the provider's existing accounting system. Under these conditions, review of the following records is optional.
 3. Basic accounting records, such as general ledger; subsidiary ledgers; and cash journals, which include checkbooks, bank statements, reconciliations and voided checks.
 4. Accounting books, records and documents (including electronic storage media) maintained in accordance with generally accepted accounting principles and practices (GAAPP) that sufficiently and properly reflect all revenues and expenditures of funds provided by the Managing Entity.
 5. Accounting procedures and policies to determine the Provider's strengths and any possible weaknesses.
- G. Activities in Contract Accountability Review
The following may be discussed at or following the entrance conference: 1) activities, developments, and concerns that have arisen since any previous contract compliance review; 2) special provisions of the current Contract and changes in staff, consumers, state laws and rules; 3) the sampling procedure, request of records or interviews; 4) interviews, when used, may be set up in advance if the individuals are not readily available at the site; 5) procedures to be utilized; 6) the scope of the compliance review; 7) the anticipated time for the compliance review; and 8) identification of key players.
 1. For purposes of assuring programmatic financial integrity is maintained, the accuracy of contract payments as they relate to programmatic requirements and service quality may be reviewed. This includes:

- Determining compliance with related corrective actions documented in the contract manager file.
 - Determining correction of all identified deficiencies noted in the previous Contract Accountability Report.
 - Interim financial statements, including the latest financial statements available to the Provider's board of directors. As part of financial statement examination, financial ratios and measures of financial condition may be utilized to assess the Provider's ability to meet its current obligations as well as its solvency or liquidity.
 - The chart of accounts.
 - A current operating budget and expenditure report.
 - Records of all sources of income (i.e., each fund that contributes to the provision of services and in-kind contribution/match documentation).
 - Records and minutes of board and finance committee meetings.
 - The methodology for service allocation by programs and cost centers along with proper documentation of each service. The service unit records, logs, reports, and client files utilized for billing may be reviewed in order to verify billing and service delivery accuracy.
 - When required, a roster of all Provider employees.
 - Copies of statements for agency-supplied employee credit cards.
 - Current organizational chart.
2. In reviewing the financial records, must be able to trace financial transactions from the individual purchase order(s), voucher(s), receiving reports or invoices, journals, and the general ledger to ensure appropriate processing by the Provider organization.
- a. In a fixed price contract, payment is based on a price per unit. The following should be verified:
- (1) The documentation supporting units of service delivered supports the units listed for payment.
 - (2) The payment received versus the amount invoiced is the same, using the contract as a reference.
 - (3) Copies of expenditure reports submitted by the Provider, if applicable, are in compliance with contract requirements.
- b. In a cost reimbursement contract, the Provider is reimbursed for actual expenditures incurred during the contract period, and reviewed to identify any irregularities. To assure:
- (1) Revisions have been properly made to the operating budget (for example, transfer of funds from salaried employees to other budget items).
 - (2) Expenditures were:
Made in accordance with the approved line item budget.
Incurred or encumbered during the contract period.
 - (3) Adequate documentation demonstrates professional service fees are based on time spent and allowable expenditures agreed upon; receipts are available for any purchases made from outside vendors or where expenditures were made (e.g., office supplies, printing, long distance calls); usage logs are available for in-house postage meters; records are available for names of recipients where service was provided; and the Provider has complied with all applicable rules for cost reimbursement as specified in its contract.

3. Verification the Provider has retention requirements in its policies and procedures consistent with the contract requirements, at a minimum.
- H. Exclusions - State, regional or local government agencies under contract may submit a current written report describing internal oversight in lieu of receiving onsite Administrative Review. The monitoring must be for the current contract period and the report shall contain sufficient information to assure the services have been provided and contract expenditures are appropriate and allowable per the terms and conditions of the Contract. The Provider shall submit a copy of the monitoring report to the Provider Relations Specialist no later than July 15 of each fiscal year. Unless information is received indicating contract non-compliance by the governmental agency or its subcontractors, the report may be accepted in lieu of onsite Review. Concordia Behavioral Health reserves the right to conduct an Administrative Review even with the receipt of a current report from the governmental agency.
- I. Contract Accountability Review Report - The Report documents the ability to ensure appropriate contracting procedures are in place; service delivery as contractually required and the extent to which the Provider has been fiscally responsible in accounting for public funds. A deficiency denotes contractual non-compliance with the terms and conditions of the contract. Non-compliance may include a deficiency in internal control, fraud, illegal act, abuse and violation of contract provisions or grant agreements. When significant issues of non-compliance are identified, to the extent possible, protocols (policies, procedures and contract provisions) are used to determine the findings, thereby facilitating the development of the Report. The Report shall contain a description of the deficiency, including the facts that led to the conclusion; a description of the standard against what is measured, i.e., federal, statutes, rules or policy, etc.; a brief description of the potential risk if the deficiency is not corrected; a synopsis of the contract background, including amendments; a summary of the deficiencies identified; the date(s) of the Review; Concordia participants and Provider representatives; a description of the type of sample, and the type(s) and number of files reviewed. All client and confidential staff information shall be redacted from the Report and working papers prior to distribution. The Report shall be furnished to the Provider no more than thirty (30) calendar days from the date of the site visit exit interview. When electronic transmission is used, the Provider Relations Specialist shall include receipt of delivery in the contract file.
- J. Corrective Action Plan (CAP) - The following is a list of critical matters that must be immediately addressed:
1. Any threat to the health, safety or welfare to consumers, staff or the public, including a reasonable probability a threat could occur if remedial action is not initiated without delay.
 2. Misuse, waste, loss of a significant or egregious lack of judgment in the use of public funds.
 3. Indications state or federal laws, state rules or federal regulations have been violated.
- A moratorium may be placed on referrals when a critical deficiency is identified or as determined appropriate by the Chief Operating Officer and the ME CEO.
- K. Exit Interview - Upon completion of the site visit, an exit interview with the Provider's representatives involved in the Review is conducted. At a minimum, the following is obtained: a written record of the participants; review the preliminary findings; allow the Provider with an opportunity to furnish additional or supporting documentation not provided during the site visit; review next steps including when the Report will be sent, how it will be delivered and to whom it will be sent, timeframes and method for the Provider to submit a response and a review of critical and/or potential areas of

concern; and provide feedback concerning exceptional practices implemented by the Provider.

- L. Verification Site Visit - After receipt of the Provider's corrective action plan, the Provider Relations Specialist schedules a Verification Site Visit to ascertain the successful implementation of the corrective action plan. The Verification Site Visit may be conducted by properly trained staff, and not necessarily the assigned Provider Relations Specialist. Verification Site Visits are limited in scope – review of the corrective action plan – and brief in duration. If there is continued non-compliance after a second Verification Site Visit, a meeting will be scheduled with the Provider's leadership team to discuss the deficiency, the expectations and concerns, final deadlines for correction and possible sanctions if continued failure is determined. This may include Cure and/or contract termination.
- M. Reports
1. Purpose - Findings and any other relevant information is communicated by preparing and submitting a written report to the Provider. The report documents the Provider's compliance with the terms and conditions of the contract and the delivery of services to the consumers as outlined in the contract.
 2. Report - Completed and forward to the Provider within thirty (30) calendar days from the date of the Exit Conference. In turn, the Provider shall have thirty (30) calendar days from the date of the Report cover letter to respond to the findings detailed in the Report. Areas addressed in the report includes: demographic information, executive summary, scope/purpose, background information, documents reviewed, sample size, findings, observations, and summary. NOTE: Notification may be sent to the Provider prior to the complete Report to advise of any deficiency requiring immediate attention.
 3. Report Fields - Below is a description of additional data fields and directions on what information is required in each Report.
 - a. Executive Summary: An executive summary contains enough information for readers to become acquainted with the document's content without having to read it. Its purpose is to give the reader an overview of the information contained in the report. The executive summary will provide a synopsis, based on the information reviewed, of the Provider's compliance or performance.
 - b. Purpose: This section provides a brief overview or outline of the services reviewed including the date of the last compliance review of the contract, recent findings and any areas needing follow-up during the current, scheduled, or upcoming visit.
 - c. Background Information: This section provides brief information on the Provider history related to services of this contract. Additionally, this section provides an overview of all contract actions, which may include recent amendments, increases or decreases in funding, and/or change of services.
 - d. Documents Reviewed: This section contains information regarding which documents were reviewed to determine contract compliance. Documents may include, but are not limited to: contract documents, Provider's proposal, policy and procedure manuals, client records, training files, incident reports, personnel files, client satisfaction surveys, staff satisfaction surveys, organization charts, invoices, self-

monitoring reports, finance and compliance audit reports, other Review instruments, etc.

- e. Sample Size/Description of file.
- f. Findings/Deficiencies: This section details the results derived from the Review and addresses areas the Provider was found to be non-compliant with the terms and conditions of the contract. This section describes the specific authority or source of the requirement (Contract, Statute, Rule, or Policy, etc). Deficiencies from a previous compliance reviews not corrected are also detailed in this section. Each finding/deficiency in the report will note if a corrective action plan is needed for that deficiency and will identify the deficiency type as a minor or major deficiency.
- g. Observations/Comments: This section provides a brief description of observations and/or comments resulting from the Review.
- h. Summary: This section provides a brief statement that presents the main points of previously stated facts or statements in a concise form; identifies if an additional visit is necessary due to the findings; outlines tentative next steps, if applicable. Additionally, Provider comments from the entrance or exit may be included in this section.
- i. Timeframe: The Report includes deadlines for Provider's to submit a response.

Definitions

1. Administrative Review – The review of a Provider's compliance with the terms and conditions of a contract, such as financial management, eligible expenditures, audit compliance, personnel standards, and other provisions incidental to the direct services delivered to consumers. This may include conducting an annual inventory, annual audit review, assessing adherence to invoice and report submission, and development and adherence to operational policies and procedures.
2. Administrative Standards – Criteria used to evaluate a Provider's compliance with contract provisions.
3. Amendment – A document by which changes are made to the terms of an executed contract that alters specified terms and conditions of the original Contract. Changes requiring an amendment of the contract include, but are not limited to, corrections or modifications to costs, services, time period, and/or method of payment.
4. Attachment – A supplement to the contract that contains the unique program specific provisions of the contract and may include the following sections: Services to be Provided, Manner of Service Provision, Method of Payment, and Special Provisions.
5. Budget – A plan that outlines anticipated revenues and expenditures.
6. Compliance – The complete fulfillment of the terms and conditions of the Contract in accordance with policies, rules, and regulations.
7. Confidential Information – Materials obtained and compiled as part of a contract compliance review that are non-public records and not discussed with or disclosed to anyone except supervisor. After the final report is submitted records containing protected information such as client and employee identification remains confidential and is not subject to public records disclosure.
8. Contract – A formal written agreement between the Managing Entity and an organization for the delivery of services. The contract includes general terms and conditions, a scope of services, exhibits, attachments, amendments, renewal(s), and those portions of the Provider's proposal that have been incorporated by reference. Pursuant to Chapter 287,

- Florida Statutes, a contract must be executed by both parties and in effect prior to services being rendered.
9. Contract Accountability Review - The active oversight of Provider performance and includes the acquisition, review, reporting, and follow-up on information to ensure (1) the Providers' compliance with terms and conditions of contracts and any applicable laws, rules, policies, and procedures; (2) the Providers' fiscal responsibility; and (3) corrective actions are implemented if required.
 10. Contract Accountability Review Plan – The annual compilation of activities to be conducted as part of assessing compliance for each contract. This includes the staff responsible for each activity, the instruments to be utilized, the frequency and timeline for completion, and the justification for each activity.
 11. Contract Closeout – The final process taken upon completion or termination of a contract. This procedure may include such operations as processing final payment or recovering any overpayment.
 12. Contract Default – The failure to perform or meet one or more contract provisions.
 13. Contract Duration – The length of time for which a contract is legally binding on both parties. It is normally specified in the contract under the “effective” and “ending” dates.
 14. Contract File – The collection of documents containing information related to the operation of the program, contract, invoicing and payment, and other contract-related documents. The file is maintained by the Contract Manager/Provider Relations Specialist.
 15. Contract Terms– The conditions, obligations, rights, price, and other provisions required of the contracted parties.
 16. Corrective Action – Outcome-based measures of remediation the Provider develops and implements in response to findings of unacceptable performance, non-performance, or non-compliance with the terms and conditions of a contract. Corrective action plans must be outcome-based measures of remediation with short-, mid-, and long-term benchmarks to accomplish the corrective action.
 17. Critical Issue – A Provider's failure to provide a component essential to service delivery or the verification the delivery of an essential service has been compromised.
 18. Cure Letter – Written notice to the Provider of a deficiency or deficiencies in the Provider's performance under the contract, which may result in termination of the contract unless corrected within a specified timeframe.
 19. Data Security – The protection of confidential information from unauthorized use, modification, destruction, disclosure, or dissemination.
 20. Department – Florida Department of Children and Families or DCF, unless otherwise stated.
 21. Disallowable Expenditures – Expenses not included in the contractual agreement, and therefore are deemed inappropriate for payment.
 22. Entrance Conference – The meeting with the Provider to present expectations for the onsite review, including the topic and scope of the review through completion of the applicable Instrument to assess contract compliance and to follow up on any pending corrective action plans.
 23. Exhibit – An attachment to the contract that contains contract terms and conditions not specific to the program/services delivered.
 24. Exit Conference – The final step of an onsite visit where immediate feedback is offered to the Provider and outlines problems, issues, or deficiencies identified during the Review and provides preliminary notice and timeframes for of any necessary corrective action.
 25. Findings – Material results and observations derived from the Review that identify the Provider's failure to comply with specific terms and conditions of the contract as it relates to the Provider's service delivery, operations, and financial stability. A finding will result in a demand for correction.

26. Instruments – Tools used to conduct a Review and are the major reference materials used to document the review and used to enable other appropriate parties to see the evidence that supports conclusions and recommendations.
27. Major Deficiencies – A finding that present risks to the continuous delivery of quality services; the receipt of public funds for program services not delivered; or repeated minor deficiencies that indicate no progress in correcting the deficiency. If left unaddressed, may result in financial penalties or contract termination.
28. Manner of Service Provision – The section of the contract detailing the service tasks, staffing requirements, service location and equipment, deliverables, performance specifications, Provider responsibilities, and outcome measures and performance standards for the contract. The Manner of Service Provision is sometimes referred to as “Services to Be Provided” and “Scope of Services.”
29. Minor Deficiencies – Unintentional and non-systemic mistakes that do not result in reduced or substandard program service nor are fraudulent transactions. Minor deficiencies can be readily adjusted without the need of a corrective action plan or penalties.
30. Performance Standards – Quantitative statements that specify the level of accomplishment of an outcome or output measure contained in the Provider’s contract.
31. Programmatic Review– Assessment of consumer services and activities carried out by the Providers through a review of documents submitted, interviews with consumers and/or staff, financial documents, and completion of Review instruments during a site visit.
32. Provider Relations Specialist – Employee responsible for enforcing performance of the contract terms and conditions and serves as a liaison between the Managing Entity and the subcontracted provider.
33. Qualified Audit Opinion - issued when an independent auditor discovers something in the financial statements is subject to major concern.
34. Quality Assurance –the systematic approach to assessing and improving services resulting in an effective and efficient system to produce desired outcomes. The approach includes the identification of areas to improve; ongoing assessment of achievement in meeting performance measures; and utilizing data gathered to drive enhancements and improvements.
35. Reference Guide for State Expenditures – The Guide developed by the Florida Department of Financial Services, Division of Accounting and Auditing, Bureau of Auditing, that provides information regarding requirements applicable to various categories of spending public funds.
36. Readiness Assessment – A review conducted within thirty (30) calendar days of contract start/service delivery to assess the Provider’s readiness to meet contract terms and conditions.
37. Risk Assessment – The instrument used to determine the frequency of site visits to the program utilizing pre-established risk criteria.
38. Risk Levels-The degree of risk (low, medium, or high) assigned to each Provider based upon risk assumed with the contract, as determined by the completion of the Risk Assessment Instrument.
39. Subcontract – A written contract between the Provider and the Managing Entity to deliver program services. The subcontract contains all applicable terms and conditions of the original contract between the Department and the Managing Entity.
40. Terms and conditions of contract – Administrative and programmatic requirements mandated of the all parties to an agreement.
41. Unannounced Visits – Onsite visits conducted during normal business hours and/or non-traditional hours, which are not prearranged with the Provider.
42. Unqualified Audit Opinion – A type of audit opinion that provides reasonable assurance the financial statements of an entity present fairly the financial position, results of operations, and cash flows in conformity with generally accepted accounting principles.



CEO/President Approval:	CMO Approval:
Date:	Date: