REQUEST FOR PROPOSAL

HEALTH INSURANCE PROGRAM
FOR
PEOPLE LIVING WITH HIV INFECTION IN LOUISIANA

OFFICE OF PUBLIC HEALTH
STD/HIV PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS

RFP # _305PUR-DHHRFP-HIP/HIV-OPH
Proposal Due Date/Time: July 8, 2013
4:00 P.M. CDT

Release Date: June 5, 2013

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ADA **Glossary and Acronyms**

P: AIDS Drug Assistance Program (national)
AIDS: Acquired Immunodeficiency Syndrome
CAREWare: free, scalable software for managing and monitoring Ryan White Services
CBO: Community Based Organization
CMS: Centers for Medicare and Medicaid Services
COB: Coordination of Benefits
COBRA: Consolidated Omnibus Budget Reconciliation Act
CQI: Continuous Quality Improvement
CT: Central Time
DHH: Department of Health and Hospitals
"Emergency" an instance that places a client in jeopardy of losing his or her health insurance coverage and/or benefits
EOB: Explanation of Benefits
FPL: Federal Poverty Level
HIP: Health Insurance Program
HITECH: Health Information Technology for Economic and Clinical Health Act
HIV: Human Immunodeficiency Virus
HRSA: Health Resources and Services Administration
LA ADAP: Louisiana AIDS Drug Assistance Program (local)
LHP: Louisiana Health Plan
LIS: Low Income Subsidy
Must: Denotes a mandatory requirement
Original: Denotes must be signed in ink
OPH: Office of Public Health
PBM: Pharmacy Benefits Manager
PCIP: Pre-existing Condition Insurance Plan
PPACA: Patient Protection and Affordable Care Act
Redacted Proposal: The removal of alleged confidential and/or proprietary information from one copy of the proposal for public records purposes.
RFP – Request for Proposals
Shall, Will: Denote a mandatory requirement
SHP: STD/HIV Program
Should, Can, May: Denote a preference, but not a mandatory requirement
SOB: Summary of Benefits
STD: Sexually Transmitted Disease
TA: Technical Assistance
TAB Coordinator: Treatment Access and Benefits Coordinator
Transaction Fee: cost to execute a claim

I. GENERAL INFORMATION

A. Background

1. The mission of the Department of Health and Hospitals (DHH) is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. The Department of Health and Hospitals is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner.

2. DHH is comprised of Medical Vendor Administration (Medicaid), Office for Citizens with Developmental Disabilities, Office of Behavioral Health, Office of Aging and Adult Services, and the Office of Public Health. Under the general supervision of the Secretary, these principal offices perform the primary functions and duties assigned to DHH.

3. DHH, in addition to encompassing the program offices, has an administrative office known as the Office of the Secretary, a financial office known as the Office of Management and Finance, and various bureaus and boards. The Office of the Secretary is responsible for establishing policy and administering operations, programs, and affairs.

4. The STD/HIV Program (SHP), located within the Office of Public Health (OPH), is responsible for coordinating the state's response to the STD/HIV epidemics. The program conducts activities to: 1) provide medical and social services to persons with HIV infection and treat persons diagnosed with an STD, 2) prevent new cases of HIV and STD infection, and 3) collect data and compile, analyze and distribute information about the progression of the HIV and STD epidemics in the state.

B. Purpose of RFP

1. The purpose of this RFP is to solicit proposals from qualified proposers that provide administrative and fiduciary services for the statewide Health Insurance Program (HIP) for persons living with HIV in Louisiana. The goal of HIP is to provide assistance to low-income individuals living with HIV with the payment of their health insurance premiums and eligible cost shares, including co-payments, co-insurances and deductibles. This program assists individuals by maintaining access to healthcare through their current providers while allowing the flexibility to access more options in healthcare services. It is a cost effective program in that it helps HIV infected individuals access essential medical services by utilizing their health insurance and keeps individuals from relying on the Louisiana AIDS Drug Assistance Program (ADAP), the State funded health care system or Louisiana Medicaid. In addition, by maintaining the health insurance of individuals, it is more likely that medical care will be maintained and drug therapy accessed, which in turn will lead to improved health outcomes.

   People living with HIV may encounter many financial and physical hardships during the course of their disease progression. HIP was implemented to reduce

the medical and financial burdens associated with the client accessing HIV-related primary to health care and medications.

2. A contract is necessary to assist with the processing of eligibility applications and the timely payment of health insurance premiums, co-payments, and deductibles for eligible HIV- infected clients residing in the State of Louisiana who are enrolled in HIP. Eligibility requirements are established by SHP and are in accordance with Health Resources and Services Administration (HRSA) guidelines regarding the Ryan White legislation.

C. Invitation to Propose

DHH Office of Public Health, STD/HIV Program (SHP) is inviting qualified proposers to submit proposals for services to act as program administrator and fiduciary agent for the statewide Health Insurance Program for low income persons living with HIV in accordance with the specifications and conditions set forth herein.

D. RFP Coordinator

1. Requests for copies of the RFP and written questions or inquiries must be directed to the RFP coordinator listed below:

   Heather Weaver, LCSW
   Treatment Access and Benefits Coordinator
   STD/HIV Program
   Department of Health and Hospitals
   1450 Poydras St, Suite 2136
   504-568-7474
   504-568-3157 (fax)
   heather.weaver@la.gov

2. This RFP is available in PDF format at the following weblinks:
   http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm and
   http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

3. All communications relating to this RFP must be directed to the DHH RFP contact person named above. All communications between Proposers and other DHH staff members concerning this RFP are strictly prohibited. Failure to comply with these requirements may result in proposal disqualification.

E. Proposer Inquiries

1. The Department will consider written inquiries regarding the RFP or Scope of Services which are received on or before the date specified in the Schedule of Events. To be considered, written inquiries and requests for clarification of the content of this RFP must be received at the above address or via the above fax number or email address by the date specified in the Schedule of Events. Any and all questions directed to the RFP coordinator will be deemed to require an official response and a copy of all questions and

answers will be posted by the date specified in the Schedule of Events to the following web link:
http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm
and may also be posted at:
http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

2. Action taken as a result of verbal discussion shall not be binding on the Department. Only written communication and clarification from the RFP Coordinator shall be considered binding.

F. Pre-Proposal Conference (non-mandatory)

1. A non-mandatory pre-proposal conference will be held on the date and time listed on the Schedule of Events. Prospective proposers are encouraged to participate in the conference to obtain clarification of the requirements of the RFP and to receive answers to relevant questions.

2. Although impromptu questions will be permitted and spontaneous answers will be provided during the conference, the only official answer or position of the State will be stated in writing in response to written questions. Therefore, proposers should submit all questions in writing (even if an answer has already been given to an oral question). After the conference, questions will be researched and the official response will be posted on the Internet at the following link:

http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm

and may also be posted at:

http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

STD/HIV Program www.hiv.dhh.louisiana.gov

LA HIV411 www.hiv411.org

3. Attendees are strongly encouraged to advise the RFP Coordinator within five (5) calendar days of the scheduled pre-proposal conference of any special accommodations needed for persons with disabilities who will be attending the conference and/or meeting so that these accommodations can be made in advance.

G. Schedule of Events

DHH reserves the right to deviate from this Schedule of Events

Schedule of Events	Tentative Schedule
Public Notice of RFP.	June 5, 2013
Pre-Proposal Conference	June 12, 2013 9:00am-5:00pm CT Benson Tower SHP Office 1450 Poydras St., Ste.2136 New Orleans, LA 70112
Deadline for Receipt of Written Questions	June 13, 2013 4:00P.M. CT
Response to Written Questions	June 19, 2013
Deadline for Receipt of Written Proposals	July 8, 2013 4:00P.M. CT .
Proposal Evaluation	July 15-19, 2013
On Site Presentations/Demonstrations (Proposers reasonably susceptible of being selected for the award may be invited to provide On Site presentations or demonstrations of services	July 22, 2013 9:00am-5:00pm CT Benson Tower/SHP Office 1450 Poydras St., Ste.2136 New Orleans, LA 70112
Contract Award Announced	July 23, 2013
Contract Negotiations Begin	July 29, 2013
Contract Begins	September 1, 2013

H. RFP Addenda

In the event it becomes necessary to revise any portion of the RFP for any reason, the Department shall post addenda, supplements, and/or amendments to all potential proposers known to have received the RFP. Additionally, all such supplements shall be posted at the following web address:
http://wwwprd1.doa.louisiana.gov/OSP/LaPAC/pubMain.cfm
and may also be posted at:
http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

It is the responsibility of the proposer to check the DOA website for addenda to the RFP, if any.

II. Scope of Work

A. Project Overview

The result of this contract will be to provide assistance to low income individuals living with HIV infection with the payment of their health insurance premiums and eligible co-payments, co-insurances, and deductibles. The contractor

selected for this project will be expected to act as the program administrator and fiduciary agent for the Louisiana Health Insurance Program (HIP) of the STD/HIV Program. The successful proposer will be responsible for daily operation of HIP, and will manage the ongoing program requirements mandated by the STD/HIV Program of the Office of Public Health and HRSA, the federal funder.

The Contractor will provide services to eligible clients with health insurance coverage through Medicare, the Federal Pre-existing Condition Insurance Plan (PCIP), Louisiana Health Plan (LHP), COBRA, private insurance (including group and individual policies) as well as health insurance plans that participate in the PPACA Health Insurance Marketplaces. The contractor will coordinate with a comprehensive network of medical care providers and health insurance companies, and provide reporting that meets client level data requirements of LA ADAP and the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009). Eligibility determination services for all of the persons applying to HIP will be performed by a separate entity. The Contractor must have or be able to develop a mechanism to electronically receive and provide eligibility information that matches the data requirements of SHP and HRSA. SHP will retain authority in the development and management of HIP eligibility criteria and services definitions.

B. Deliverables

Programmatic/Information Sharing Requirements
Contractor shall:

1. Provide technical assistance (TA) based on provider agencies' needs and requests, about accessing HIP services to community-based organizations, medical care providers, and case managers throughout the state. Depending on the scope of the requests, technical assistance may be provided via telephone or during scheduled provider trainings which occur an average of five times each year. A report of TA requests and activities shall be included in the Contractor's quarterly report.

2. Maintain current contact information on provider agencies, medical care providers, and health insurance providers, including Medicare, the Federal Pre-existing Condition Insurance Plan (PCIP), Louisiana Health Plan (LHP), COBRA, private insurance (including group and individual policies) as well as health insurance plans that participate in the PPACA Health Insurance Marketplacesto include, but not be limited to email addresses, telephone numbers, and mailing list of physical addresses.

3. Assign a contact person to respond to customer service inquiries. This individual must have customer service experience, be trained and knowledgeable of the program's services, and have access to client-level information to

respond to participants' inquiries regarding program enrollment and coverage information.

4. Maintain a toll-free number, which shall be staffed during regular business hours (Monday-Friday, 8:00am-5:30 pm CT). A voice mail system must be maintained for telephone calls received after hours and during state and/or federal holidays, with response to messages occurring the next business day.

5. Provide HIP information, including program eligibility requirements, a description of the application process, and federal/state/local updates to referring providers and potential clients, bi-annually or as program procedures change, by flyers, mail outs, fax, and/or email,

6. Maintain monthly contact with the SHP Treatment Access and Benefits (TAB) Coordinator to review and discuss program objectives and contract performance. Contractor shall have a designated personnel member to communicate routinely with SHP personnel.

7. Participate in and/or present reports at relevant SHP meetings, including but not limited to, relevant CQI Steering Committee and sub-committee meetings, monthly monitoring meetings, SHP Services staff meetings, and other relevant HIV services planning meetings.

8. Disseminate HIP-related information to case management agencies and other service providers by presenting program enrollment and client utilization information at an average of five statewide trainings and/or meetings per year.

9. Develop, in conjunction with SHP, program related forms and correspondence. As needed, forms will be modified based on changes to third-party payer programs and to comply with federal and state reporting requirements. Any revised forms shall be submitted to OPH/SHP for approval. This shall include, but is not limited to:
    - application forms;
    - recertification forms;
    - standard communication documents (such as form letters, faxes, etc.)
    - any documents to announce program changes, and
    - flyers/brochures.

10. Be responsible for all correspondence required in the program, including but not limited to:
    - Client correspondence;
    - Medical care provider correspondence; and
    - Health Insurance company correspondence.

Invoicing/Payment Requirements

Contractor shall:

1. Process all eligible premium, copayment, coinsurance, and/or deductible payments for enrolled clients on a monthly or quarterly basis or as otherwise stipulated by a health insurance company. HIP currently provides premium and medical cost share payment services to an average of 1,700 clients each year. However, with the implementation of the PPACA Health Insurance Marketplaces in 2014, that number is expected to increase.

2. Within 10 business days of receiving enrollment notification of an eligible client, notify the client by letter of their enrollment and commence payment of health insurance premiums on a monthly or quarterly basis, unless otherwise indicated by the health insurance company.

3. Within 10 business days of receipt of bill/invoice, forward payments as it relates to clients' premium, co-payments, co-insurance and/or deductible costs to medical care providers.

4. Within one business day, process any emergency payments required for client. "Emergency" is defined as an instance that places a client in jeopardy of losing his or her health insurance coverage and/or benefits.

5. Within 10 business days, work with provider agencies to resolve billing issues. All billing issues will be paid within 10 business days after the issue has been resolved.

6. Forward all billing issues that are outstanding beyond a 30-day period to the OPH/SHP TAB Coordinator for assistance.

7. Include in each monthly invoice all payments made and credits/refunds received during the previous 30-day period.

Record Keeping/Data Management Requirements

Contractor shall:

1. Maintain a file on each client enrolled in HIP that includes all enrollment eligibility and service provision documents as determined by SHP.

2. Document individual transactions for each client through CAREWare in order to satisfy requirements of funding agency, such as invoicing, reporting and evaluation. These data shall include but are not limited to:
   - each payment made on behalf of a client;
   - total monthly expenditures;
   - dates of diagnostic visits;
   - dates of lab visits;
   - dates of office visits;
   - dates of outpatient hospital visits;
   - premium amount and affiliated coverage period;

- co-payment amount for each transaction; and
- deductible amount for each transaction.

3. Comply with all SHP and HRSA reporting requirements.

4. Coordinate with OPH/SHP's Services Data Management Coordinator and Services Data Management Supervisor for technical assistance with CAREWare.

5. Maintain a detailed report of all payments forwarded to and refunds received from medical care providers and health insurance companies.

6. Maintain financial documentation to support all payments for each calendar month that program is in operation.

7. Keep a copy of the original health insurance policy, including the Summary of Benefits (SOB), and all financial transactions, including the Explanation of Benefits (EOB) for each eligible client.

8. Undergo an annual independent financial audit in compliance with state auditing requirements. Such audit is an operational expense and shall not be paid for from contractual funds. The audit report shall be submitted to the Office of Risk Management and SHP Business Unit for review within 30 days of completion. If any deficiencies are found as a result of the audit, the contractor shall be required to rectify such issues within 30 days. If contractor does not rectify the audit issues within the 30 day time frame, the contract will be subject to termination.

9. Be compliant with all confidentiality requirements imposed by Louisiana law, DHH rules and guidelines, the HIPAA Privacy and Security Rules, the federal HITECH Act of 2009, and other applicable federal laws and regulations. Confidential information shall include not only sensitive health and risk-related information, but also client personal identifiers, potentially identifying information, and any information provided to the Contractor for which confidentiality was assured when the individual or establishment provided the information. Extremely stringent standards of client confidentiality must be maintained. The use of client information for commercial purposes shall be prohibited. Likewise, the Contractor shall not publish any information about program participants, even in the aggregate, without SHP review and prior written permission.

Quality Assurance/Monitoring Requirements
Contractor shall:

1. Produce monthly, quarterly, and annual reports to monitor service utilization and expenditures and to ensure that program is being implemented and delivered as required. A brief description of each report can be found in the Procurement Library.

2. Prior to delivering services, establish and submit to SHP for approval a quality assurance and monitoring protocol. This protocol shall include at a minimum a plan to:

   Internally review 5% of all active client files on a quarterly basis. For each of

the client files reviewed, the contractor must verify the accuracy of information entered into, or imported into CAREWare. The minimal data elements to verify include:

- Client contact and health insurance information;
- Number of services provided;
- Total expenditures from the beginning of each grant year and the total expenditures for each quarter;
- Number of co-payments; and
- Number of payments made towards a deductible.

3. An external review of a minimum of 10% of all active client files shall be conducted on an annual basis, by the TAB Coordinator and/or the Services Quality Manager/Program Evaluator.

4. Conduct annual client satisfaction surveys, collecting information from a minimum of 20% of enrolled clients. The contents of the survey shall be submitted to SHP for approval before distribution, and a compilation of the results shall be provided to SHP upon completion.

5. Conduct an annual survey of referring providers to collect information regarding the effectiveness and efficiency of HIP from a minimum of 60% of referring providers.

6. Have a policy or protocol that outlines clients' "Rights and Responsibilities" and maintain a client grievance policy.

Transition Plan
Contractor shall:
Have a detailed transition plan that will successfully transition contractor activities upon termination of the contract without interrupting services to clients.

C. Liquidated Damages

1. In the event the Contractor fails to meet the performance standards specified within the contract, the liquidated damages defined below may be assessed. If assessed, the liquidated damages will be used to reduce the Department's payments to the Contractor, or if the liquidated damages exceed amounts due from the Department, the Contractor will be required to make cash payments for the amount in excess.

    a. Late submission of a SHP required report - $50 per working day, per report.
    b. Late submission of a required HRSA related report– $100 per working day, per report.
    c. Failure to maintain all client files and perform all file updates according to the requirements in the contract, as evidenced in client files when reviewed during monitoring site visit - $100 per client file.
    d. Late submission of invoices - $50 per working day per invoice.

e. Failure to provide a solution based response to a client grievance within 30 days from the date that the grievance is filed. - $50 per working day, per documented grievance.

2. The decision to impose liquidated damages shall include consideration of some or all of the following factors:
   a. The duration of the violation;
   b. Whether the violation (or one that is substantially similar) has previously occurred;
   c. The Contractor's history of compliance;
   d. The severity of the violation and whether it imposes an immediate threat to the health or safety of the consumers; and/or
   e. The "good faith" exercised by the Contractor in attempting to stay in compliance.

D. Fraud and Abuse

1. The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.

2. Such policies and procedures must be in accordance with state and federal regulations. Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

E. Technical Requirements

The Contractor must maintain hardware and software compatible with current DHH requirements, which are as follows:

- IBM compatible PC
- Intel Core i5 or equivalent (or compatible successors)
- 4 Gig of RAM memory (minimum)
- Enough spare USB ports to accommodate thumb drives, etc.
- 250GB Hard Drive (minimum)
- Ethernet LAN interface for laptop and desktop PCs
- 19" WXGA Digital Flat Panel LCD monitor with DVI (minimum)
- Printer compatible with hardware and software required
- High speed internet with email
- DVD\CD ROM
- Windows XP, SP3 or later version of operating system (minimum)
- Windows Internet Explorer 8.0 (or later)
- Microsoft Office 2007 or later
- Appropriate firewalls for internet security
- Compliant with industry-standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.).

F. Subcontracting

The contractor shall not contract with any other party for furnishing any of the work and professional services required by the contract without the express prior written approval of the Department. The contractor shall not substitute any subcontractor without the prior written approval of the Department. For

subcontractor(s), before commencing work, the contractor will provide letters of agreement, contracts or other forms of commitment which demonstrates that all requirements pertaining to the contractor will be satisfied by all subcontractors through the following:

1. The subcontractor(s) will provide a written commitment to accept all contract provisions.
2. The subcontractor(s) will provide a written commitment to adhere to an established system of accounting and financial controls adequate to permit the effective administration of the contract.

G. Insurance Requirements

Insurance shall be placed with insurers with an A.M. Best's rating of no less than A-: VI. This rating requirement shall be waived for Worker's Compensation coverage only.

1. Contractor's Insurance

   The Contractor shall not commence work under this contract until it has obtained all insurance required herein. Certificates of Insurance, fully executed by officers of the Insurance Company shall be filed with the Department for approval. The Contractor shall not allow any subContractor to commence work on subcontract until all similar insurance required for the subcontractor has been obtained and approved. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of the Department before work is commenced. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days notice in advance to the Department and consented to by the Department in writing and the policies shall so provide.

2. Workers' Compensation Insurance

   Before any work is commenced, the Contractor shall obtain and maintain during the life of the contract, Workers' Compensation Insurance for all of the Contractor's employees employed to provide services under the contract. In case any work is sublet, the Contractor shall require the subcontractor similarly to provide Workers' Compensation Insurance for all the latter's employees, unless such employees are covered by the protection afforded by the Contractor. In case any class of employees engaged in work under the contract at the site of the project is not protected under the Workers' Compensation Statute, the Contractor shall provide for any such employees, and shall further provide or cause any and all subcontractors to provide Employer's Liability Insurance for the protection of such employees not protected by the Workers' Compensation Statute.

3. Commercial General Liability Insurance

   The Contractor shall maintain during the life of the contract such Commercial General Liability Insurance which shall protect Contractor, the Department, and any subcontractor during the performance of work covered by the

contract from claims or damages for personal injury, including accidental death, as well as for claims for property damages, which may arise from operations under the contract, whether such operations be by the Contractor or by a subcontractor, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to the Department. Such insurance shall name the Department as additional insured for claims arising from or as the result of the operations of the Contactor or its subcontractors. In the absence of specific regulations, the amount of coverage shall be as follows: Commercial General Liability Insurance, including bodily injury, property damage and contractual liability, with combined single limits of $1,000,000.

4. Insurance Covering Special Hazards
   Special hazards as determined by the Department shall be covered by rider or riders in the Commercial General Liability Insurance Policy or policies herein elsewhere required to be furnished by the Contractor, or by separate policies of insurance in the amounts as defined in any Special Conditions of the contract included therewith.

5. Licensed and Non-Licensed Motor Vehicles
   The Contractor shall maintain during the life of the contract, Automobile Liability Insurance in an amount not less than combined single limits of $1,000,000 per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the contract on the site of the work to be performed thereunder, unless such coverage is included in insurance elsewhere specified.

6. Subcontractor's Insurance
   The Contractor shall require that any and all subcontractors, which are not protected under the Contractor's own insurance policies, take and maintain insurance of the same nature and in the same amounts as required of the Contractor.

H. Resources Available to Contractor

The Office of Public Health STD/HIV Program will have an assigned personnel member who will be responsible for primary oversight of the contract. This individual will schedule meetings to discuss progress of activities and problems identified.

I. Contact Personnel

All work performed by the Contractor will be monitored by the contract monitor:

Heather Weaver
Treatment Access and Benefits Coordinator
Department of Health and Hospitals
Office of Public Health - STD/HIV Program
1450 Poydras St, Suite 2136
504-568-7474
504-568-7044 (fax)
heather.weaver@la.gov

J. Term of Contract

The contract shall commence on or near the date approximated in the Schedule of Events. The term of this contract shall be for a period of 36 months. The continuation of this contract is contingent upon the availability of funds from the United States Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) to fulfill the requirements of the contract.

K. Payment

The contractor shall submit deliverables in accordance with established timelines and shall submit itemized invoices monthly or as defined in the contract terms. Payment of invoices is subject to approval of STD/HIV Program Administrative Director.

III. PROPOSALS

A. General Information

This section outlines the provisions which govern determination of compliance of each proposer's response to the RFP. The Department shall determine, at its sole discretion, whether or not the requirements have been reasonably met. Omissions of required information shall be grounds for rejection of the proposal by the Department.

B. Contact After Solicitation Deadline

After the date for receipt of proposals, no proposer-initiated contact relative to the solicitation will be allowed between the proposers and DHH until an award is made.

C. Code of Ethics

Proposers are responsible for determining that there will be no conflict or violation of the Ethics Code if their company is awarded the contract. The Louisiana Board of Ethics is the only entity which can officially rule on ethics issues.

D. Rejection and Cancellation

Issuance of this solicitation does not constitute a commitment by DHH to award a contract or contracts. The Department reserves the right to reject all proposals received in response to this solicitation.

In accordance with the provisions of LA R.S. 39:2192, in awarding contracts after August 15, 2010, any public entity is authorized to reject a proposal or bid from, or not award the contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or nolo contendere to any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the laws governing public contracts under the provisions of Chapter 10 of Title 38 of the Louisiana Revised Statutes of 1950, professional, personal, consulting, and social services procurement under the provisions of Chapter 16 of this Title, or the Louisiana Procurement Code under the provisions of Chapter 17 of this Title.

E. Award Without Discussion

The Secretary of DHH reserves the right to make an award without presentations by proposers or further discussion of proposals received.

F. Assignments

Any assignment, pledge, joint venture, hypothecation of right or responsibility to any person, firm or corporation should be fully explained and detailed in the proposal. Information as to the experience and qualifications of proposed subcontractors or joint ventures should be included in the proposal. In addition, written commitments from any subcontractors or joint ventures should be included as part of the proposal.

G. Proposal Cost

The proposer assumes sole responsibility for any and all costs associated with the preparation and reproduction of any proposal submitted in response to this RFP, and shall not include this cost or any portion thereof in the proposed contract price

H. Errors and Omissions

The State reserves the right to make corrections due to minor errors of proposer identified in proposals by State or the proposer. The State, at its option, has the right to request clarification or additional information from proposer.

I. Ownership of Proposal

All proposals become the property of the Department and will not be returned to

the proposer. The Department retains the right to use any and all ideas or adaptations of ideas contained in any proposal received in response to this solicitation. Selection or rejection of the offer will not affect this right. Once a contract is awarded, all proposals will become subject to the Louisiana Public Records Act.

J. Procurement Library/Resources Available To Proposer

Relevant material related to this RFP will be posted at the following web address*: www.hiv.dhh.la.gov*

K. Proposal Submission

1. All proposals must be received by the due date and time indicated on the Schedule of Events. Proposals received after the due date and time will not be considered. It is the sole responsibility of each proposer to assure that its proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.

2. Proposer shall submit one (1) original hard copy (The Certification Statement must have original signature signed in ink) and should submit one (1) electronic copy (cd or flash drive) of the entire proposal and six (6)hard copies of each proposal. Proposer may provide one electronic copy redacted (cd or flash drive). No facsimile or emailed proposals will be accepted. The cost proposal and financial statements should be submitted separately from the technical proposal; however, for mailing purposes, all packages may be shipped in one container.

3. Proposals must be submitted via U.S. mail, courier or hand delivered to:

If courier mail or hand delivered:
Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
628 N 4th Street, 5th Floor
Baton Rouge, LA 70802

If delivered via US Mail:
Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
P.O. Box 1526
Baton Rouge, LA 70821-1526

L. Proprietary and/or Confidential Information

Pursuant to the Louisiana Public Records Act (La. R.S. 44.1 et. seq.), all public proceedings, records, contracts, and other public documents relating to this RFP shall be open to public inspection. Proposers should refer to the Louisiana Public Records Act for further clarification.

M. Proposal Format

1. An item-by-item response to the Request for Proposals is requested.

2. There is no intent to limit the content of the proposals, and proposers may include any additional information deemed pertinent. Emphasis should be on simple, straightforward and concise statements of the proposer's ability to satisfy the requirements of the RFP.

N. Requested Proposal Outline:

- Introduction/Administrative Data
- Work Plan/Project Execution
- Relevant Corporate Experience
- Personnel Qualifications
- Additional Information
- Corporate Financial Condition
- Cost and Pricing Analysis

O. Proposal Content

1. Proposals should include information that will assist the Department in determining the level of quality and timeliness that may be expected. The Department shall determine, at its sole discretion, whether or not the RFP provisions have been reasonably met. The proposal should describe the background and capabilities of the proposer, give details on how the services will be provided, and shall include a breakdown of proposed costs. It should also include information that will assist the Department in determining the level of quality and timeliness that may be expected. Work samples may be included as part of the proposal.

2. Proposals should address how the proposer intends to assume complete responsibility for timely performance of all contractual responsibilities in accordance with federal and state laws, regulations, policies, and procedures.

3. Proposals should define proposer’s functional approach in providing services and identify the tasks necessary to meet the RFP requirements of the provision of services, as outlined in Section II.

4. Introduction/Administrative Data

    a. The introductory section should contain summary information about the proposer's organization. This section should state proposer’s knowledge and understanding of the needs and objectives of DHH Office of Public Health STD/HIV Program as related to the scope of this RFP. It should further cite its ability to satisfy provisions of the Request for Proposal.

b. This introductory section should include a description of how the proposer's organizational components communicate and work together in both an administrative and functional capacity from the top down. This section should contain a brief summary setting out the proposer's management philosophy including, but not limited to, the role of Quality Control, Professional Practices, Supervision, Distribution of Work and Communication Systems. This section should include an organizational chart displaying the proposer's overall structure.

c. This section should also include the following information:
    i. Location of Active Office with Full Time Personnel, include all office locations (address) with full time personnel.
    ii. Name and address of principal officer;
    iii. Name and address for purpose of issuing checks and/or drafts;
    iv. For corporations, a statement listing name(s) and address(es) of principal owners who hold five percent interest or more in the corporation.
    v. If out-of-state proposer, give name and address of local representative; if none, so state;
    vi. If any of the proposer's personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and social security number;
    vii. If the proposer was engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state; and
    viii. Proposer's state and federal tax identification numbers.
    ix. Veteran/Hudson Initiative: Proposer should demonstrate participation in Veteran Initiative and Hudson Initiative Small Entrepreneurships or explanation if not applicable. (See Attachment I)

d. The following information must be included in the proposal:
    i. Certification Statement: The proposer must sign and submit an original Certification Statement (See Attachment II).

5. Work Plan/Project Execution

The proposer should articulate an understanding of, and ability to effectively implement, services as outlined within Section II of the RFP. In this section the proposer should state the approach it intends to use in achieving each objective of the project as outlined, including a project work plan and schedule for implementation. In particular, the proposer should describe the plan for providing administrative and fiduciary services for the statewide Health Insurance Program (HIP) to provide assistance to low-income individuals living with HIV with the payment of their health insurance premiums and eligible co-payments and deductibles consistent with this RFP. Please note that client eligibility determination services for HIP clients are not included in this RFP.

The work plan should include narrative addressing the following:

- Describe the proposer's existing relationships with health insurance companies and medical care providers in Louisiana or the proposer's ability and experience in developing such relationships.

- Describe the ability to provide premium and medical care copayment/ coinsurance payments for clients. Also, include a description of the mechanism by which communication with health insurance companies and medical care providers will occur in order to inform them of significant events and/or program changes.

- Provide documentation of the emergency response/preparedness plan and describe how all clients will be transitioned to available services in the event of an emergency.

Claims Processing

Describe how the proposer will make payments to health insurance companies and medical care providers. Include expected time needed to process payments as well as a plan for tracking and documenting receipt of payments.

Provide a plan for achieving accurate client level data management and providing client support services.

Provide a detailed description of the recoupment process that will be performed to include type(s) of software used, third party vendor(s) used (if any), frequency at which tasks are performed, and how claims data and premium payment information will be communicated to SHP, health insurance companies and medical care providers.

Describe how the proposer will monitor billings to assure non-duplication and the proper split between primary, secondary and (if applicable) tertiary payers. Include an explanation of recoupment and reimbursement procedures.

Describe the proposer's ability and experience in coordinating and communicating with health insurance providers such as including Medicare, the Federal Pre-existing Condition Insurance Plan (PCIP), Louisiana Health Plan (LHP), COBRA, private insurance (including group and individual policies) as well as health insurance plans that participate in the PPACA Health Insurance Marketplaces

Describe in detail the workflow process between medical care providers, health insurance providers (such as Medicare, the Federal Pre-existing Condition Insurance Plan (PCIP), Louisiana Health Plan (LHP), COBRA, private insurance (including group and individual policies) as well as health insurance plans that participate in the PPACA Health Insurance Marketplaces), clients, CBOs, SHP personnel and the proposer. The description should include timelines for accomplishments, as well as flowcharts or other visual presentations of the process.

a. Provide information regarding the capability to split bill and track multiple payer sources such as Medicare, the Federal Pre-existing Condition

Insurance Plan (PCIP), Louisiana Health Plan (LHP), COBRA, private insurance (including group and individual policies), and SHP.

b. Describe how the process identified in item (a) above will prevent SHP from making erroneous payments. Include how the proposer will ensure that SHP does not pay for services that are not covered by a client's health insurance or from a time period when the client was not enrolled in HIP.

c. Describe the process for obtaining credits and adjustments on behalf of SHP, within 90 day, for any possible overpayments that have been made.

d. Describe the system to effectively monitor deductible and benefit caps for each client.

e. Provide information on the capability to pay incurred expenses on behalf of HIP clients at the point of service and bill SHP afterwards.

Technical support

Describe the proposer's ability and experience in providing training and technical support to SHP personnel, CBOs, medical care providers, health insurance companies, and clients. Include a description of the levels of service that are provided at various times during the day. For example, describe the level of service available during business hours versus the type of support provided during non-business hours, including holiday and weekend hours. Also include a description of how the proposer ensures that there is adequate personnel who are trained to provide coverage during transition times, such as when key personnel position becomes vacant. Describe the ability to document problem resolution.

Explain the ability to participate in, and/or present reports at, relevant SHP meetings, including but not limited to, the CQI Steering Committee and subcommittee meetings, monthly monitoring meetings, SHP Services staff meetings, and other relevant planning and monitoring meetings.

Describe the proposer's ability to participate in SHP trainings and/or meetings at SHP's direction, to assist in presenting program information to contracted CBOs, medical centers and other service providers. Include examples of training tools and resources the proposer can make available to clients, case managers and other caregivers.

Data system

Maintain a data system that is capable of receiving and managing client eligibility information to use for claims processing, premium payments, monthly invoicing, as well as the generation of reports and billing.

Describe the proposer's ability and experience to create and manage data systems that receive detailed client eligibility information from SHP and provide it for payment information to medical care providers and health insurance companies. Include a description of how the proposer ensures that medical care providers and health insurance companies are informed of client eligibility.. If applicable, include information about tools available to SHP through the proposer's systems, including but not limited to remote access, report builders and claims data review.

Describe the ability to submit a monthly electronic data file of all transactions provided to individual eligible clients, to include client and claim level data. Include a description of the type of data file that will be provided and how it will be transmitted to SHP.

Describe in detail any initial, and subsequent, network/hardware/software/system requirements that SHP would need to have in order to electronically interface with the proposer's program/system. Include any special software or hardware that would need to be installed on SHP computers. If the interface is web-based, specify if it will be fully compatible with Windows Internet Explorer Version 8.0 or above. Include description of how the interface provide secure/encrypted data transmission in compliance with all DHH rules and guidelines, the HIPAA Security Rule, the federal HITECH Act of 2009, and other applicable federal laws and regulations.

Describe the proposer's ability to create custom reports that describe monthly user activity and cost of services. Include a description

Describe the ability to provide standardized monthly utilization and expenditure reports. Include how will this report be submitted to SHP personnel and in what format (i.e., PDF, Excel, Word).

Monthly Payment

Describe the proposer's ability and experience in providing premium payment to the health insurance companies and cost share payment to medical care providers upfront for the duration of a month while preparing an invoice to SHP at the end of each month. Include a description of how the proposer ensures that payment is only requested for valid cost; include details about the reimbursement quality assurance processes that eliminate duplicate or invalid reimbursement.

Describe the ability to create and provide a monthly, claims-level transaction file in electronic format.

Treatment Adherence

Treatment adherence is defined as services provided to encourage, support, and enhance adherence to and compliance with treatment regimens, including related medical monitoring.

Describe your current experience or ability to provide treatment adherence activities to increase and support adherence to medical care and/or assist clients monitor their progress in adhering to

HIV-related medical care.

Client Confidentiality

Client confidentiality is extremely important. The Contractor must be compliant with all confidentiality requirements imposed by Louisiana law, DHH rules and guidelines, the HIPAA Privacy and Security Rules, the federal HITECH Act of 2009, and other applicable federal laws and regulations. Confidential information shall include not only sensitive health and risk-related information, but also client personal identifiers, potentially identifying information, and any other information provided to the Contractor for which confidentiality was assured when the individual or establishment provided the information. Extremely stringent standards of client confidentiality must be maintained and the use of client information for commercial purposes is not allowed. Likewise, the Contractor may not publish any information about program participants, even in the aggregate, without SHP review and written permission.

Describe the proposer's ability and experience in assuring client confidentiality. Describe in detail any security or confidentiality breaches experienced by the company in the past five years. Also, describe how the proposer protects client information from being used for commercial purposes or published, even in the aggregate, without SHP review and written permission.

Provide a detailed description of how secure data will be transmitted between the various parties involved in service coordination (SHP, health insurance plans, , and medical care providers), to comply with DHH rules and guidelines, the HIPAA Security Rule, and the federal HITECH Act of 2009, as well as satisfying industry standards and practices.

Quality Assurance/Monitoring Requirements

Describe current quality assurance activities and measures, including the ability and timeline required to produce utilization and expenditure reports.

Describe the experience or ability to conduct client satisfaction and provider surveys. Include examples of previous survey tools and outcomes as an attachment.

Provide documentation of the policy or protocol that outlines clients' "Rights and Responsibilities" as an attachment. Provide a copy of the current grievance policy as an attachment.

Transition Plan

Describe in detail the plan and the proposed timeline to successfully transition clients from the current HIP contractor to the new Contractor.

Explain how Contractor activities and client files would be transitioned upon termination of the contract without interrupting services to clients.

Fraud and Abuse

Describe the fiscal controls and accounting practices that assure against fraud or abuse of funds, including the fiscal accountability of any proposed sub-vendors. Include a description of how you would take corrective/disciplinary action upon detection of fraud or abuse, and describe how you would notify SHP.

1. Relevant Corporate Experience
    a. The proposal should indicate the firm has a record of prior successful experience in the design and implementation of the services sought through this RFP. Proposers should include statements specifying the extent of responsibility on prior projects and a description of the projects scope and similarity to the projects outlined in this RFP. All experience under this section should be in sufficient detail to allow an adequate evaluation by the Department. The proposer should have, within the last 24 months completed a similar type project. Proposers should give at least two customer references for projects completed in at least the last 24 months. References should include the name, email address and telephone number of each contact person.

    b. In this section, a statement of the proposer's involvement in litigation that could affect this work should be included. If no such litigation exists, proposer should so state.

2. Personnel Qualifications
    a. The purpose of this section is to evaluate the relevant experience, resources, and qualifications of the proposed personnel to be assigned to this project. The experience of proposer's personnel in implementing similar services to those to be provided under this RFP will be evaluated. The adequacy of personnel for the proposed project team will be evaluated on the basis of project tasks assigned, allocation of personnel, professional skill mix, and level of involvement of personnel.

    b. Proposers should state job responsibilities, workload and lines of supervision. An organizational chart identifying individuals and their job titles and major job duties should be included. The organizational chart should show lines of responsibility and authority.

Proposer should:

    a. Provide a Staffing and Organization Plan required to complete the proposed work.

    b. Provide a list and overview of staffing positions needed to successfully meet the program objectives. Include business hours of operation and primary methods of contact.

    c. Describe the responsibilities and qualifications of key personnel. Note: any personnel replaced during the period of performance of any resulting contract must be replaced with personnel with equivalent or superior qualifications.

d. Describe the responsibilities and qualifications of any sub-Contractor who would likely be assigned to this contract.

e. Describe how the proposer ensures that functions of the contract will be maintained in the absence of key personnel. For example, if a personnel member leaves unexpectedly, describe who would assume his/her duties and how quickly that would happen. The proposer should have an emergency preparedness plan in place and included in the proposal as an attachment.

f. Describe how implementation of the Staffing and Organization Plan will be consistent with the designated contract start date and services start date, as listed in this RFP.

g. Job descriptions, including the percentage of time allocated to the project and the number of personnel should be included and should indicate minimum education, training, experience, special skills and other qualifications for each personnel position as well as specific job duties identified in the proposal. Job descriptions should indicate if the position will be filled by a sub-Contractor.

h. Key personnel and the percentage of time directly assigned to the project should be identified.

i. Résumés of all known personnel should be included. Resumes of proposed personnel should include, but not be limited to:

- Experience with proposer,
- Previous experience in projects of similar scope and size.
- Educational background, certifications, licenses, special skills, etc.

j. If subcontractor personnel will be used, the proposer should clearly identify these persons, if known, and provide the same information requested for the proposer's personnel.

3. Additional Information

As an appendix to its proposal, if available, proposers should provide copies of any policies and procedures manuals applicable to this contract, inclusive of organizational standards or ethical standards. This appendix should also include a copy of proposer's All Hazards Response Plan, if available.

4. Corporate Financial Condition

a. The organization's financial solvency will be evaluated. The proposer's ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be considered.

b. Proposal should include for each of the last three (3) years, copies of financial statements, preferably audited, including at least a balance sheet and profit and loss statement, or other appropriate documentation which would demonstrate to the Department the proposer's financial resources sufficient to conduct the project.

5. Cost and Pricing Analysis
   a. Proposer shall specify costs for performance of tasks for each year of the contract. Proposal shall include all anticipated costs of successful implementation of all deliverables outlined. An item-by-item breakdown of costs shall be included in the proposal.

   b. Proposers shall submit the breakdown in a similar format, and are strongly encourage to use the same format as the attached sample cost template form (See Attachment V) for each year of the contract to demonstrate how cost was determined.

   c. Administrative costs may include usual and recognized overhead activities, including rent, utilities, and facility costs as well as costs of management oversight of specific programs funded under this title, including program coordination; clerical, financial, and management personnel not directly related to patient care; program evaluation; liability insurance; audits; computer hardware/ software not directly related to patient care.

      However, in accordance with the legislative mandates of the Ryan White HIV/AIDS Treatment Extension Act of 2009, and the Monitoring Standards for Ryan White Part A and B Grantees, Administrative Costs must be documented and shall not exceed 10% of the total resources contracted for direct client services.

P. Evaluation Criteria

The following criteria will be used to evaluate proposals:

1. Evaluations will be conducted by a Proposal Review Committee.

2. Evaluations of the financial statements will be conducted by a member of the DHH Fiscal Division.

3. Scoring will be based on a possible total of 100 and the proposal with the highest total score will be recommended for award.

4. Cost Evaluation:
   a. The proposer with the lowest total cost for all 3 years shall receive *25* points. Other proposers shall receive points for cost based upon the following formula:

      CPS = (LPC/PC)* *25*

CPS = Cost Proposal Score
LPC = Lowest Proposal Cost of all proposers
PC = Individual Proposal Cost

b. The assignment of the *25* points based on the above formula will be calculated by a member of the DHH Contracts Office staff.

5. Evaluation Criteria and Assigned Weights:

Evaluation Criteria	*Assigned Weight*
Introduction/Understanding of RFP	15
Work Plan/Project Execution	30
Corporate Experience	5
Qualification of Personnel	10
Financial Statements	5
Cost	25
Veterans/Hudson Initiatives	10
Total	100

Q. On-Site Presentations/Demonstrations

1. The Department may select the proposers susceptible of being awarded the contract for an on-site presentation and/or demonstration for final determination of contract award. On-site presentations/demonstrations will allow proposers to demonstrate their unique capability to provide the services requested in the RFP.

2. Proposers selected for on-site presentations/demonstrations should:
   - Provide a strategic overview of services to be provided,
   - Summarize major strengths,
   - Demonstrate flexibility and adaptability to handle both anticipated and unanticipated changes,
   - If possible, have the project manager and key personnel in attendance to provide their view of the partnership envisioned with SHP.

3. Up to an additional 10 points may be awarded as a result of the on-site presentation/demonstration.

R. Announcement of Award

The Department will award the contract to the proposer with the highest graded

proposal and deemed to be in the best interest of the Department. All proposers will be notified of the contract award. The Department will notify the successful proposer and proceed to negotiate contract terms.

IV. CONTRACTUAL INFORMATION

A. The contract between DHH and the Contractor shall include the standard DHH contract form (CF-1/attached) including a negotiated scope of work, the RFP and its amendments and addenda, and the Contractor's proposal. The attached CF-1 contains basic information and general terms and conditions of the contract to be awarded.

B. Mutual Obligations and Responsibilities: The state requires that the mutual obligations and responsibilities of DHH and the successful proposer be recorded in a written contract. While final wording will be resolved at contract time, the intent of the provisions will not be altered and will include all provisions as specified in the attached CF-1.

C. Retainage-The Department, shall secure a retainage of 10% from all billings under the contract as surety for performance. On successful completion of contract deliverables, the retainage amount may be released on an annual basis. Within ninety (90) days of the termination of the contract, if the contractor has performed the contract services to the satisfaction of the Department and all invoices appear to be correct, DHH shall release all retained amounts to the contractor.

D. In addition, to terms of the CF-1 and supplements, the following will be incorporated into the contract awarded through this RFP:

1. Personnel Assignments: The Contractor's key personnel assigned to this contract may not be replaced without the written consent of the Department. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. Key personnel for these purposes will be determined during contract negotiation.

2. Force Majeure: The contractor and the Department are excused from performance under contract for any period they may be prevented from performance by an Act of God, strike, war, civil disturbance, epidemic or court order.

3. Order of Precedence: The contract shall, to the extent possible, be construed to give effect to all provisions contained therein; however, where provisions conflict, the intent of the parties shall be determined by giving a first priority to provisions of the contract excluding the RFP and the proposal; second priority to the provisions of the RFP; and third priority to the provisions of the proposal.

4. Entire Agreement: This contract, together with the RFP and addenda issued thereto by the Department, the proposal submitted by the contractor in response to the Department's RFP, and any exhibits specifically incorporated herein by

reference constitute the entire agreement between the parties with respect o the subject matter.

5. Board Resolution/Signature Authority: The contractor, if a corporation, shall secure and attach to the contract a formal Board Resolution indicating the signatory to the contract is a corporate representative and authorized to sign said contract.

6. Warranty to Comply with State and Federal Regulations: The contractor shall warrant that it shall comply with all state and federal regulations as they exist at the time of the contract or as subsequently amended.

7. Warranty of Removal of Conflict of Interest: The contractor shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The contractor shall periodically inquire of its officers and employees concerning such conflicts, and shall inform the Department promptly of any potential conflict. The contractor shall warrant that it shall remove any conflict of interest prior to signing the contract.

8. If the contractor is a corporation, the following requirement must be met prior to execution of the contract:
   a. If a for-profit corporation whose stock is not publicly traded-the contractor must file a Disclosure of Ownership form with the Louisiana Secretary of State.
   b. If the contractor is a corporation not incorporated under the laws of the State of Louisiana-the contractor must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.
   c. The contractor must provide written assurance to the agency from contractor's legal counsel that the contractor is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the contract.

Attachments:

I. Veteran and Hudson Initiatives
II. Certification Statement
III. DHH Standard Contract Form (CF-1)
IV. HIPAA Business Associate Addendum
V. Cost Template
VI. ADR Final Client Level Data Variables
VII. HRSA HAB Part B Fiscal Monitoring Standards
VIII. HRSA HAB Part B Program Monitoring Standards

Attachment I

Minimum Required Language - Request For Proposal (RFP)
Veteran-Owned and Service-Connected Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) Programs

Participation of Veteran Initiative and Hudson Initiative small entrepreneurships will be scored as part of the technical evaluation.

The State of Louisiana Veteran and Hudson Initiatives are designed to provide additional opportunities for Louisiana-based small entrepreneurships (sometimes referred to as LaVet's and SE's respectively) to participate in contracting and procurement with the state. A certified Veteran-Owned and Service-Connected Disabled Veteran-Owned small entrepreneurship (LaVet) and a Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) small entrepreneurship are businesses that have been certified by the Louisiana Department of Economic Development. All eligible vendors are encouraged to become certified. Qualification requirements and online certification are available at https://smallbiz.louisianaforward.com/index_2.asp.

Ten percent (10%) of the total evaluation points on this RFP are reserved for proposers who are themselves a certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiatives small entrepreneurships as subcontractors.

Reserved points shall be added to the applicable proposers' evaluation score as follows:

Proposer Status and Reserved Points

- Proposer is a certified small entrepreneurship: Full amount of the reserved points
- Proposer is not a certified small entrepreneurship but has engaged one or more certified small entrepreneurships to participate as subcontractors or distributors. Points will be allocated based on the following criteria:
  -the number of certified small entrepreneurships to be utilized
  -the experience and qualifications of the certified small entrepreneurship(s)
  -the anticipated earnings to accrue to the certified small entrepreneurship(s)

If a proposer is not a certified small entrepreneurship as described herein, but plans to use certified small entrepreneurship(s), proposer shall include in their proposal the names of their certified Veteran Initiative or Hudson Initiative small entrepreneurship subcontractor(s), a description of the work each will perform, and the dollar value of each subcontract.

During the term of the contract and at expiration, the Contractor will also be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship subcontractor or distributor participation and the dollar amount of each.

The statutes (R.S 39:2171 *et. seq.)* concerning the Veteran Initiative may be viewed at http://legis.la.gov/lss/lss.asp?doc=671504; and the statutes (R.S 39:2001 *et. seq.)* concerning the Hudson Initiative may be viewed at

http:/legis.la.gov/lss/lss.asp?doc=96265. The rules for the Veteran Initiative (LAC 19:VII. Chapters 11 and 15) and for the Hudson Initiative (LAC 19:VIII Chapters 11 and 13) may be viewed at http://www.doa.louisiana.gov/osp/se/se.htm.

A current list of certified Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurships may be obtained from the Louisiana Economic Development Certification System at https://smallbiz.louisianaforward.com/index_2.asp. Additionally, a list of Hudson and Veteran Initiative small entrepreneurships, which have been certified by the Louisiana Department of Economic Development and who have opted to register in the State of Louisiana LaGov Supplier Portal https://lagoverpvendor.doa.louisiana.gov/irj/portal/anonymous?guest_user=self_reg may be accessed from the State of Louisiana Procurement and Contract (LaPAC) Network http://wwwprd.doa.louisiana.gov/osp/lapac/vendor/srchven.asp. When using this site, determine the search criteria (i.e. alphabetized list of all certified vendors, by commodities, etc.) and select SmallE, VSE, or DVSE.

Rev. 12/1/11

CERTIFICATION STATEMENT ATTACHMENT II

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT. The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Print Clearly)

Date	
Official Contact Name	
Email Address	
Fax Number with Area Code	
Telephone Number	
Street Address	
City, State, and Zip	

Proposer certifies that the above information is true and grants permission to the Department to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, proposer certifies that:

1. The information contained in its response to this RFP is accurate;
2. Proposer accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's quote is valid for at least 120 days from the date of proposal's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have 10 business days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov

Authorized Signature: _____
(Original signature only. Photocopy or electronic not accepted.)

Typed or Printed Name: _____

Title: _____

Company Name: _____

CFMS:
DHH:
AGENCY #

Attachment III
DHH - CF - 1

CONTRACT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

AND

FOR

☐ Personal Services ☐ Professional Services ☐ Consulting Services ☐ Social Services

1) **Contractor (Legal Name if Corporation)**	5) **Federal Employer Tax ID# or Social Security #** (11 digits)
2) **Street Address**	6) **Parish(es) Served**
City and State **Zip Code**	7) **License or Certification #**
3) **Telephone Number**	8) **Contractor Status** Subrecipient: ☐ Yes ☐ No Corporation: ☐ Yes ☐ No For Profit: ☐ Yes ☐ No Publicly Traded: ☐ Yes ☐ No
4) **Mailing Address (if different)**	
City and State **Zip Code**	8a) **CFDA#**(Federal Grant #)

9) **Brief Description Of Services To Be Provided:**
Include description of work to be performed and objectives to be met; description of reports or other deliverables and dates to be received (when applicable). In a consulting service, a resume of key contract personnel performing duties under the terms of the contract and amount of effort each will provide under terms of contract should be attached.

10) **Effective Date**	11) **Termination Date**

12) This contract may be terminated by either party upon giving thirty (30) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.

13) **Maximum Contract Amount**

14) **Terms of Payment**
If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows: (stipulate rate or standard of payment, billing intervals, invoicing provisions, etc.). Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	**Name**	
	Title	**Phone Number**

15) **Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):**

During the performance of this agreement, the Contractor hereby agrees to the following terms and conditions:

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U.

S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.

2. Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)

3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

   Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Department of Health and Hospitals, Attention: **Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating DHH Office.**

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.

5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of Contractual Review.

6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds, and shall maintain, at Contractor's expense, all necessary insurance for its employees, including but not limited to automobile insurance, workers' compensation and general liability insurance.

7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.

8. In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.

9. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

10. Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.

11. All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.

12. Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.

13. No person and no entity providing services pursuant to this contract on behalf of contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 42:1113 as amended in the 2008 Regular Session of the Louisiana Legislature.

14. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.

15. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502.

16. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

17. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if contract exceeds $20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

18. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.

19. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.

20. Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.

21. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.

22. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

23. Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

	STATE OF LOUISIANA **DEPARTMENT OF HEALTH AND HOSPITALS**
_____	_____
SIGNATURE **DATE**	**SIGNATURE** **DATE**
_____	_____
NAME	**NAME**
_____	Secretary, Department of Health and Hospitals or Designee
TITLE	**TITLE**
_____	_____
SIGNATURE **DATE**	**SIGNATURE** **DATE**
_____	_____
NAME	**NAME**
_____	_____
TITLE	**TITLE**

(Rev. 1/04)

HIPAA Business Associate Addendum:

This Business Associate Addendum is hereby made a part of this contract in its entirety as Attachment __ to the contract.

1. The U. S. Department of Health and Human Services has issued final regulations, pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), governing the privacy of individually identifiable health information. See 45 CFR Parts 160 and 164 (the "HIPAA Privacy Rule"). The Department of Health and Hospitals, ("DHH"), as a "Covered Entity" as defined by HIPAA, is a provider of health care, a health plan, or otherwise has possession, custody or control of health care information or records.
2. "*Protected health information*" ("PHI") means individually identifiable health information including all information, data, documentation and records, including but not limited to demographic, medical and financial information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual or payment for health care provided to an individual; and that identifies the individual or which DHH believes could be used to identify the individual.

   "*Electronic protected health information*" means PHI that is transmitted by electronic media or maintained in electronic media.

   "*Security incident*" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
3. Contractor is considered a Business Associate of DHH, as contractor either: (A) performs certain functions on behalf of or for DHH involving the use or disclosure of protected individually identifiable health information by DHH to contractor, or the creation or receipt of PHI by contractor on behalf of DHH; or (B) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, financial or social services for DHH involving the disclosure of PHI.
4. Contractor agrees that all PHI obtained as a result of this contractual agreement shall be kept confidential by contractor, its agents, employees, successors and assigns as required by HIPAA law and regulations and by this contract and addendum.
5. Contractor agrees to use or disclose PHI solely (A) for meeting its obligations under this contract, or (B) as required by law, rule or regulation or as otherwise permitted under this contract or the HIPAA Privacy Rule.
6. Contractor agrees that at termination of the contract, or upon request of DHH, whichever occurs first, contractor will return or destroy (at the option of DHH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor will extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.
7. Contractor will ensure that its agents, employees, subcontractors or others to whom it provides PHI received by or created by contractor on behalf of DHH agree to the same restrictions and conditions that apply to contractor with respect to such information. Contractor also agrees to take all reasonable steps to ensure that its employees', agents' or subcontractors' actions or omissions do not cause contractor to breach the terms of this Addendum. Contractor will use all appropriate safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this contract and Addendum.
8. Contractor shall, within 3 days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and Addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1.

9. Contractor shall make available such information in its possession which is required for DHH to provide an accounting of disclosures in accordance with 45 CFR 164.528. In the event that a request for accounting is made directly to contractor, contractor shall forward such request to DHH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR 164.528 for at least six (6) years after the date of the last such disclosure.
10. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR 164.524.
11. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR 164.526.
12. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of DHH available to the Secretary of the U. S. DHHS for purposes of determining DHH's compliance with the HIPAA Privacy Rule.
13. Compliance with Security Regulations:

    In addition to the other provisions of this Addendum, if Contractor creates, receives, maintains, or transmits electronic PHI on DHH's behalf, Contractor shall, no later than April 20, 2005:

    (A) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DHH;

    (B) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and

    (C) Report to DHH any security incident of which it becomes aware.
14. Contractor agrees to indemnify and hold DHH harmless from and against all liability and costs, including attorneys' fees, created by a breach of this Addendum by contractor, its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that contractor has violated any material term of this Addendum.

Attachment V
Cost Template

A. Total dedicated for the payment of health insurance premiums and eligible cost shares, including co-payments, co-insurances and deductibles

$ _____

B. Personnel and Operating Expenses (must be not more than 10% of amount in A above)

Title	Annual Salary	Effort (%)	Year (%)	Amount
				$
				$
				$
				$
				$

Total Salary Expenses **$** _____

C. Fringe Benefits (no more than 20% of salaries) **$** _____

D. Travel

In-state Mileage Expenses	$ _____	
Professional Development Expenses	$ _____	
Other (Specify)	$ _____	
Total Travel Expenses		**$** _____

E. Operating Expenses

Office Supplies and Printing	$ _____	
Postage	$ _____	
Rent	$ _____	
Telephone	$ _____	
Utilities	$ _____	
Other (specify)	$ _____	
Total Operating Expenses		**$** _____

F. Equipment **$** _____

SUB TOTAL (B-E) **$** _____

ADAP Data Report
Final Client-Level Data Variables

System Variables				
Field #	**Variable Description**	**Variable Definition**	**Allowed Values**	**Rationale**
1.	Reporting period	The report period identifier.	1 = 10/01/2012 – 03/31/2013 2 = 04/01/2013 – 09/30/2013 3 = 10/01/2013 – 03/31/2014 4 = 04/01/2014 – 09/30/2014	
2.	Encrypted UCI	The encrypted, unique client identifier generated by the HAB UCI generation utilities.	41-character string	
3.	ADAP number	The unique provider organization identifier assigned through the ADR Web Application.	State ADAP number	
Client Variables				
Client Demographics: To describe the socio-demographic characteristics of all clients enrolled in the ADAP, whether or not they received services				
4.	Ethnicity	Client's ethnicity. OMB-approved categories are used.	• Hispanic/Latino(a) • Non-Hispanic • Unknown	Description of clients served
5.	Race	Client's race. Select all that apply. OMB-approved categories are used.	• White • Black or African American • Asian • Native Hawaiian/Pacific Islander • American Indian or Alaska Native • Unknown	Description of clients served
6.	Gender	Client's current gender	• Male • Female • Transgender • Unknown	Description of clients served
7.	Transgender	Client's current transgender status. To be completed only if the response is "Transgender" in Item #6.	• Male-to-Female • Female-to-Male • Unknown	Description of clients served

ADAP Data Report
Final Client-Level Data Variables

Field #	Variable Description	Variable definition	Allowed Values	Rationale
Client Demographics: To describe the socio-demographic characteristics of all clients enrolled in the ADAP, whether or not they received services				
8.	*Pregnancy status*	*Value indicating whether the client was pregnant at any time during the reporting period. This should be completed for HIV+ women only.*	• *No (skip to #10)* • *Yes* • *Not applicable (skip to #10)* • *Unknown(skip to #10)*	*Description of clients served*
9.	*Client's year of birth*	*The year in which the client was born*	*YYYY*	*Description of clients served*
10.	*HIV/AIDS status*	*Client's HIV/AIDS status as of the end of the reporting period*	• *HIV positive, not-AIDS* • *HIV positive,AIDS status unknown* • *CDC-defined AIDS* • *Unknown*	*Description of clients served*
11.	*Poverty level*	*Client's annual household income as a percent of the Federal Poverty Level (FPL) at the end of the reporting period.*	• *Equal to or below the FPL* • *101-200% of the FPL* • *201-300% of the FPL* • *301% - 400% of the FPL* • *401% - 500% of the FPL* • *Over 500% of the FPL* • *Unknown/ unreported*	*Description of clients served*
12.	*High Risk Insurance*	*Was this client in a High Risk Insurance Pool (including Pre-Existing Condition Insurance Plans (PCIPs)) at any time during the reporting period?*	• *No* • *Yes* • *Unknown*	*Description of clients served*
13.	*Client's health insurance coverage during the reporting period*	*Indicate all sources of client's health insurance during the reporting period.* *Report all that apply.*	• *Medicare Part A/B* • *Medicare Part D* • *Medicaid* • *Private* • *Other public* • *No insurance*	*Description of clients served*

ADAP Data Report
Final Client-Level Data Variables

Field #	Variable Description	Variable definition	Allowed Values	Rationale
Enrollment and Certification: To describe client enrollment patterns and certification processes				
14.	Was the individual a new or existing client?	Newly enrolled clients in ADAP this reporting period refers to individuals who meet all of the following criteria: • applied to ADAP for the first time ever; • met the financial and medical eligibility criteria of the ADAP during the period for which you are reporting data Examples of clients who should NOT be included in this number are the following: • Clients who have been recertified as eligible or clients who have been re-enrolled after a period of having been decertified/disenrolled. • Clients who have moved out of the State and then returned, and • Clients who move on and off ADAP because of fluctuations in eligibility for a Medicaid/ Medically Needy program, based on whether they met spend-down requirements. An existing ADAP client is a client who met the following criteria: • enrolled in ADAP in a previous reporting period and; • continues to be enrolled in the current reporting period, regardless of whether they used ADAP services in either reporting period. Note: An individual enrolled in ADAP (new or existing client) may or may not use services. Use of services is not required to be an enrolled client.	• Newly enrolled client • Existing Client (skip to question #17)	HAB ADAP Performance Measures

ADAP Data Report
Final Client-Level Data Variables

Field #	Variable Description	Variable definition	Allowed Values	Rationale
Enrollment and Certification: To describe client enrollment patterns and certification processes				
15.	*What was the date of receipt of the completed client ADAP application?*	*The date that the completed application was received by the ADAP program.*	*MM/DD/YYYY*	*HAB ADAP Performance Measures*
16.	*What was the date of approval of this client's ADAP application?*	*The date that the client was approved to begin to receive ADAP services. This is when the client was first enrolled in the ADAP program.*	*MM/DD/YYYY*	*HAB ADAP Performance Measures*
17.	*What was this client's recertification date during this reporting period?*	*The date on which a client was determined to be eligible to continue to receive ADAP services.* *Note: All individuals enrolled in ADAP, regardless of whether or not they receive services, must be recertified every six months. This includes clients on a waiting list. The minimum activities for recertification include:* *1) Financial Eligibility determination.* *2) Ensuring that ADAP is the Payer of Last Resort* *3) Appropriate documentation (ie: financial/ insurance –or lack thereof/ denial of coverage)*	*MM/DD/YYYY*	*HAB ADAP Performance Measures*
18.	*What was the client's enrollment status as of the end of the reporting period?*	*The status of an individual in the ADAP program as of the end of the reporting period. There are four possible options which are:* • *The individual is enrolled in ADAP but did not need/request any services* • *The individual is enrolled in ADAP but is on a waiting list* • *The individual is enrolled in ADAP and received either ADAP-funded medications or insurance services during the reporting period* • *The individual was disenrolled from ADAP*	• *Enrolled, receiving services (skip to question #20)* • *Enrolled, on waiting list (skip to question #20)* • *Enrolled, services not requested (skip to question #20)* • *Disenrolled*	*Description of clients served*

ADAP Data Report
Final Client-Level Data Variables

Field #	Variable Description	Variable definition	Allowed Values	Rationale
Enrollment and Certification: To describe client enrollment patterns and certification processes				
19.	*What was/were the reason(s) for disenrollment?*	*Please note the reasons for disenrollment/discharge. Select all that apply. If the reason is unknown, please report under "other".*	• *Ineligible, change in ADAP* • *program FPL requirements* • *Ineligible for ADAP, now eligible for Medicaid* • *Ineligible, other reason* • *Did not recertify* • *Did not fill prescription* • *Deceased* • *Dropped out, no reason given*	*To determine service utilization*
ADAP Insurance Services Received: To describe ADAP-funded insurance assistance services and expenditures. ADAP-funded insurance assistance includes premiums, co-pays and deductibles. Co-pays and deductibles for medications should be reported in this section.				
20.	*Did this client receive any ADAP-funded insurance assistance during this reporting period, including Medicare Part D premiums?*	*This includes premiums, deductibles and co-payments for which ADAP funds were used.* *[If response to question #26 is no, go to #31]*	• *No (skip to Item #25)* • *Yes*	*To describe service utilization*
21.	*Total amount of insurance Premium paid on behalf of this client during the reporting period [not including Medicare Part D].*	*The total amount of insurance premium paid on behalf of the client. This pertains to any premium paid during the reporting period, regardless of the time frame that it covers (i.e. if it extends outside the reporting period)*	*$$$*	*To describe service utilization and to determine annualized costs by type of insurance assistance*
22.	*For how many months of coverage was this insurance Premium during the reporting period?*	*The total number of months of coverage for which insurance premium in Item #20 was paid. Please report all months even if they fall outside of the reporting period.*	*##*	*To describe service utilization and to determine annualized costs by medication type*

ADAP Data Report
Final Client-Level Data Variables

Field #	Variable Description	Variable definition	Allowed Values	Rationale
ADAP Services Received: To describe ADAP-funded insurance assistance services and expenditures. ADAP-funded insurance assistance includes premiums, co-pays and deductibles. Co-pays and deductibles for medications should be reported in this section.				
23.	*Total amount of deductible and co-pays paid on behalf of this client during the reporting period.*	*The total amount of insurance deductibles and co-pays paid on behalf of the client, not including Medicare Part D. The amount reported should be based on the date that the deductible or co-pay was paid.*	*$$$*	*To describe service utilization and to determine annualized costs by medication type*
24.	*Total amount of Medicare Part D Co-Insurance, Co-Payment or donut hole coverage (true out of pocket expenses) paid on behalf of this client during the reporting period.*	*The total amount of Medicare Part D Co-Insurance, Co-Payment or donut hole coverage (true out of pocket expenses) paid on behalf of the client during this reporting period. The amount reported should be based on the date that the co-insurance, co-payment or donut hole coverage amount was paid.*	*$$$*	*To describe service utilization and to determine annualized costs by medication type*
Drugs and Drug Expenditures: To describe the ADAP-funded medications dispensed to clients and total expenditures for those services. This section is only for clients who were dispensed ADAP-funded medications paid in full by ADAP (i.e. not clients for whom only the co-pay or deductible was paid). This includes ARVs, Hepatitis B and Hepatitis C medications.				
25.	*Were any ADAP-funded medications dispensed to this client during this reporting period?*	*Whether or not ADAP-funded medications were dispensed to this client during this reporting period? ADAP-funded medications include any medication on your ADAP formulary which was paid for in full by ADAP funds.*	• *No (skip to end)* • *Yes*	*To describe service utilization*
26.	*Please list the ADAP-funded medication dispensed to the client during this reporting period.*	*The specific list of ADAP funded medications that were dispensed to the client during the reporting period. Please use the five-digit drug code (d-xxxxx) of the medication.* *Items #26-29 will be reported for each ADAP-funded medication.*	*d######*	*To describe service utilization and to determine annualized costs by medication type*

ADAP Data Report
Final Client-Level Data Variables

Field #	Variable Description	Variable definition	Allowed Values	Rationale
Drugs and Drug Expenditures: To describe the ADAP-funded medications dispensed to clients and total expenditures for those services. This section is only for clients who were dispensed ADAP-funded medications paid in full by ADAP (i.e. not clients for whom only the co-pay or deductible was paid). This includes ARVs, Hepatitis B and Hepatitis C medications.				
27.	*What is the start date of the ADAP-funded medication dispensed to the client during this reporting period?*	*List the start date for each ADAP funded medication listed in Item #26.*	*MM/DD/YYYY*	*To describe service utilization and to determine annualized costs by medication type*
28.	*For how many days was the ADAP-funded medication dispensed?*	*The number of days for which the medication was dispensed for each ADAP funded medication listed in Item #26. Number of days should be reported in 30-day increments (i.e. 30, 60, 90).Anything less than 30 days should be reported as the actual number of days supplied (i.e. , 14)*	*##*	*To describe service utilization and to determine annualized costs by medication type*
29.	*What was the Total cost of the ADAP-funded medication dispensed to the client during the reporting period?*	*The total cost of each ADAP-funded medication dispensed during the reporting period. Include total costs of each ADAP-funded medication paid during the reporting period, even if the medication prescription period extended beyond the reporting period.*	*$$*	*To describe service utilization and to determine annualized costs by medication type*
30.	*Dispensing fees collected separately*	*Do you pay dispensing fees for medications separate from other fees such other administrative? [If yes, go to question 37)*	• *No (skip to end)* • *Yes*	*To describe service utilization and to determine annualized costs by medication type.*
31.	*What is the total cost of all Dispensing Fees for medications paid on behalf of this client during the reporting period?*	*The total cost of all dispensing fees for medications paid on behalf of the client during the reporting period. Include all costs paid during the reporting period, even if the medication period extended beyond the reporting period.*	*$$*	*To describe service utilization and to determine annualized costs by medication type.*

HIV/AIDS Bureau, Division of Service Systems
Monitoring Standards for Ryan White B Grantees: Part B Fiscal Monitoring Standards

Table of Contents

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Section A: **Limitation on Uses of Part B funding**				
1. Adherence to 10% limit on proportion of federal	• Identification and description of all	• Identify and appropriately categorize administrative	N/A	[1]RW Part B 2618 (b)(3)(A)

1 All statutory citations are to title XXVI of the Public Health Service Act, 42 U.S.C. § 300ff-11 et seq, and are abbreviated with "RW Part B" and the section reference.

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
funds spent on administrative costs in any given grant year • For grantees without a fiduciary intermediary or administrative agent	expenses within grantee budget that are categorized as administrative costs • Documentation that administrative expenses do not exceed 10% of Ryan White grant	expenses and ensure that they do not exceed 10% of total grant • Provide HRSA/HAB with current operating budgets with sufficient detail to determine and review administrative expenses		
2. Adherence to 15% limit on proportion of federal funds spent on grantee administration and planning and evaluation in any given grant year • For grantees with a fiduciary intermediary or administrative agent	• Detailed description of all expenses within grantee budget that are categorized as planning and evaluation costs • Documentation that administrative expenses and planning and evaluation expenses do not exceed 15% of Ryan White grant	• Identify and appropriately categorize planning and evaluation expenses and ensure that they do not exceed 10% of total grant • Provide HRSA/HAB with current operating budgets with sufficient detail to determine and review planning and evaluation expenses • Calculate administrative and planning and evaluation expenses to assure that collectively they do not exceed 15%		RW Part B 2618 (b)(1-3) 2618 (b) (4) Funding Opportunity Announcement
3. Use of grantee administrative funds only for allowable expenditures	Review of grantee budget to determine that all administration expenditures are allowable under HAB guidelines, based on the following list of allowable administrative activities: • Routine grant	Provide to HRSA current operating budgets and allocation expense reports with sufficient detail to review administrative expenses	N/A	RW Part B 2618(b)(3)(C)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	administration and monitoring activities, including the development of applications and the receipt and disbursal of program funds • Development and establishment of reimbursement and accounting systems • Preparation of routine programmatic and financial reports • Compliance with grant conditions and audit requirements • All activities associated with the grantee's contract award procedures, including the activities carried out by consortia, if they exist • Development of requests for proposals, subgrantee and contract proposal review activities, negotiation and awarding of contracts • Monitoring activities including telephone consultation, written documentation, and onsite visits			

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	• Reporting on contracts, and funding reallocation activities • Indirect costs			
4. Aggregated subgrantee administrative expenses total not more than 10% of Part B service dollars	• Review of subgrantee budgets to ensure proper designation and categorization of administrative costs • Calculation of the administrative costs for each subgrantee • Calculation of the total amount of administrative expenses across all subgrantees to ensure that the aggregate administrative costs do not exceed 10%	Maintain file documentation on all subgrantees including their current operating budgets and expense/ allocation reports, with sufficient detail to identify and calculate administrative expenses	Prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses	RW Part B 2617(b)(3)(B)
5. Appropriate subgrantee assignment of Ryan White Part B administrative expenses, with administrative costs to include: • Usual and recognized overhead activities, including rent, utilities, and facility costs • Costs of management oversight of specific programs funded under	Review of subgrantee administrative budgets and expenses to ensure that all expenses are allowable	• Obtain and keep on file current subgrantee operating budgets with sufficient detail to review program and administrative expenses and ensure appropriate categorization of costs • Review expense reports to ensure that all administrative costs are allowable	• Prepare project budget that meets administrative cost guidelines • Provide expense reports that track administrative expenses with sufficient detail to permit review of administrative cost elements	RW Part B 2618(b)(3)(D) Funding Opportunity Announcement 2 CFR Part 215 or OMB-21

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
this title, including program coordination; clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; computer hardware/ software not directly related to patient care ***Note:*** For institutions subject to 2 CFR Part 215 (OMB 21), the term "facilities and administration" is used to mean indirect cost				
6. Inclusion of Indirect costs (capped at 10%) only where the grantee/ subgrantee has a certified HHS-negotiated rate approved by HRSA using the Certification of Cost Allocation Plan or Certificate of Indirect Costs, which has been reviewed by the HRSA/HAB Project Officer	For grantee and subgrantees wishing to include an indirect rate, documentation of a current Certificate of Cost Allocation Plan or Certificate of Indirect Costs that is HHS-negotiated, signed by an individual at a level no lower than chief financial officer of the governmental unit that submits the proposal or component covered by the proposal, and reviewed by the HRSA/HAB Project	• File with HRSA/HAB a current approved HHS-negotiated indirect rate for the grantee • Where a subgrantee plans to use Ryan White funds for indirect costs, maintain on file the documented HRSA-approved subgrantee indirect cost rate • Review subgrantee budgets and expense reports to determine the use of the indirect cost rate	• If using indirect cost as part or all of its 10% administration costs, obtain and keep on file an HHS- negotiated, federally approved Certificate of Cost Allocation Plan or Certificate of Indirect Costs • Submit a current copy of the Certificate to the grantee	2 CFR 225 (H) (1) or OMB A-87 Appendix A Chapter II 2 CFR 230 (E) or OMB-122 Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	Officer	and adherence to the 10% administration cap		
7. Total clinical quality management costs for the State or Territory that do not exceed 5% of the annual Ryan White Part B grant or $3 million, whichever is less	Review and calculation of grantee expenditures to determine clinical quality management costs	• Provide a budget to HRSA that separately identifies all clinical quality management costs • Separately track costs associated with clinical qualify management	N/A	RW Part B 2618 (b)(3)(E)(i-ii) Funding Opportunity Announcement
8. Expenditure of not less than 75% of service dollars on core medical-related services, unless a waiver has been obtained from HRSA (Service dollars are those grant funds remaining after removal of administrative and clinical quality management funds) ***Note**:* ADAP is a core medical-related service	• Review of budgeted allocations and actual program expenses to verify that the grantee has met or exceeded the required 75% expenditure on HRSA-defined core medical services	• Monitor program allocations, subgrant agreements, actual expenditures, and reallocations throughout the year to ensure 75% percent of program funds are expended for HRSA-defined core medical services • Require subgrantee monitoring and financial reporting that documents expenditures by program service category • Maintain budgets and funding allocations, subgrantee award information, and expenditure data with sufficient detail to allow for the tracking of core medical services expenses	Report to the grantee expenses by service category	RW Part B 2618 (c)(1-2) RW Part B 2612(b)(1-2) Notice of Award

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		• If a waiver is desired, certify and provide evidence to HRSA/HAB that all core medical services funded under Part B are available to all eligible individuals in the area through other funding sources and that ADAP does not have a waiting list		
9. Total expenditures for support services limited to no more than 25% of service dollars. Support services are those services, subject to approval of the Secretary of Health and Human Services, that are needed for individuals with HIV/AIDS to achieve their medical outcomes ***Note:*** Expenditure of grant funds under Section 2611 for or through consortia are deemed to be support services, not core medical services	• Documentation that support services are being used to help achieve positive medical outcomes for clients • Documentation that aggregated support service expenses do not exceed 25% of service funds • Documentation that expenditures of grants under Section 2611 for or through consortia under this section are counted as support services, not core medical services	• Document and assess the use of support service funds to demonstrate that they are contributing to positive medical outcomes for clients • Monitor program allocations, subgrant agreements, actual expenditures, and reallocations throughout the year to ensure that no more than 25% percent of program funds are expended for HHS-approved support services • Document expenditure of funds by consortia to ensure that they are counted as support services, not core services • Require subgrantee monitoring and financial	• Report to the grantee expenses by service category • Document that support service funds are contributing to positive medical outcomes for clients	RW Part B 2613 (a)(2)(B); RW Part B 2613(f)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		reporting that documents expenditures by program service category • Maintain budgets and funding allocations, subgrantee award information, and expenditure data with sufficient detail to allow for the tracking of support service expenses		
10. Adherence to the 5 to 10 percent limit on the use of ADAP funds for access, adherence, and monitoring services	• Identification and description of expenses being used for access, monitoring, or adherence. • If expenses are higher than 5% documentation of how the additional services are essential and do not diminish access to treatment drugs • Documentation that total expenditures for access, adherence, and monitoring services do not exceed 10% of ADAP funds	• Properly identify and categorize expenses for access, adherence, and monitoring services • Ensure that 10% limit is not exceeded • Ensure that budgets submitted to HRSA provide sufficient detail to determine the percentage of ADAP fund being use of access or adherence or monitoring services.	N/A	RW Part B 2616 (c)(6)
Section B: **Unallowable Costs**				
1. The grantee shall provide to all Part B subgrantees definitions	• Signed contracts, grantee and subgrantee assurances, and/or	• Document receipt of the Notice of Award and maintain a file of signed	• Maintain a file with signed subgrant agreement, assurances, and/or	HAB Policy Notice 10-02

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
of allowable costs	certifications that define and specifically forbid the use of Ryan White funds for unallowable expenses ***Note:*** Unallowable costs are listed in the Standards for this section • Grantee review of subgrantee budgets and expenditures to ensure that they do not include any unallowable costs	assurances • Have signed certifications and disclosure forms for any subgrantee receiving more than $100,000 in direct funding • Include definitions of unallowable costs in all subgrantee requests for proposals, subgrant agreements, purchase orders, and requirements or assurances • Include in financial monitoring a review of subgrantee expenses to identify any unallowable costs • Require subgrantee budgets and expense reports with sufficient budget justification and expense detail to document that they do not include unallowable costs	certifications that specify unallowable costs • Ensure that budgets do not include unallowable costs • Ensure that expenditures do not include unallowable costs • Provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs	RW 2684 Notice of Award HAB Policy Notice 07-06
2. No use of Part B funds to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility (other than minor remodeling)	Implementation of actions specified in B.1. above	Carry out actions specified in B.1 above	Carry out subgrantee actions specified in B.1 above	RW Part B 2612 (f)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
3. No cash payments to service recipients ***Note:*** A cash payment is the use of some form of currency (paper or coins). Gift cards have an expiration date; therefore they are not considered to be cash payments	• Implementation of actions specified in B.1 above • Review of Standards of Care and other policies and procedures for service categories involving payments made on behalf of individuals to ensure that no direct payments are made to individuals (e.g., emergency financial assistance, transportation, health insurance premiums, medical or medication co-pays and deductibles, food and nutrition) • Review of expenditures by subgrantees to ensure that no cash payments were made to individuals	• Carry out actions specified in B.1 above • Ensure that Standards of Care for service categories involving payments made on behalf of clients forbid cash payments to service recipients	• Carry out subgrantee actions specified in B.1 above • Maintain documentation of policies that forbid use of Ryan White funds for cash payments to service recipients	RW Part B 2612 (f) HAB Policy Notice 10-02
4. No use of Part B funds to develop materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual	Implementation of actions specified in B.1 above	Carry out actions specified in B.1 above	Carry out subgrantee actions specified in B.1 above	RW 2684
5. No use of Part B funds for the purchase of vehicles without written	• Implementation of actions specified in B.1 above • Where vehicles were	• Carry out actions specified in B.1 above • If any vehicles were	• Carry out subgrantee actions specified in B.1 above	Notice of Award

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Grants Management Officer (GMO) approval	purchased, review of files for written permission from GMO	purchased, maintain file documentation of permission of GMO to purchase a vehicle	• If vehicle purchase is needed, seek grantee assistance in obtaining written GMO approval and maintain document in file	
6. No use of Part B funds for: • Non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.) • Broad-scope awareness activities about HIV services that target the general public	• Implementation of actions specified in B.1 above • Review of program plans, budgets, and budget narratives for marketing, promotions and advertising efforts, to determine whether they are appropriately targeted to geographic areas and/or disproportionately affected populations rather than targeting the general public	• Carry out actions specified in B.1 above • Review program plans and budget narratives for any marketing or advertising activities to ensure that they do not include unallowable costs	• Carry out subgrantee actions specified in B.1 above • Prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities	Notice of Award Part B Manual 2003 ADAP Section V Chapter 1 HAB Policy Notice 97-01
7. No use of Part B funds for outreach activities that have HIV prevention education as their exclusive purpose	• Implementation of actions specified in B.1 above	• Carry out actions specified in B.1 above • Require a detailed narrative program plan of outreach activities from subgrantees and contractors to ensure that their purpose goes beyond HIV prevention education to include testing and early entry into care	• Carry out subgrantee actions specified in B.1 above • Provide a detailed program plan of outreach activities that demonstrates how the outreach goes beyond HIV prevention education to include testing and early entry into care	HAB Policy Notice 07-06 Part B Manual 2003 ADAP Section V Chapter 1 Policy 97-01
8. No use of Part B funds	• Implementation of actions	• Carry out actions specified	• Carry out subgrantee	45 CFR 93

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
for influencing or attempting to influence members of Congress and other Federal personnel	specified in B.1. above • Review lobbying certification and disclosure forms for both the grantee and subgrantees ***Note:*** Forms can be obtained from the CFR website: http://ecfr.gpoAccess.gov	in B.1. above • File a signed "Certification Regarding Lobbying", and, as appropriate, a "Disclosure of Lobbying Activities" • Ensure that subgrantee staff are familiar and in compliance with prohibitions on lobbying with federal funds	actions specified in B.1 above • Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds	Notice of Award Dr. Parham-Hopson Letter 2/3/09
9. No use of Part B funds for foreign travel	• Implementation of actions specified in B.1. above	• Carry out actions specified in B.1 above • Request a detailed narrative from subgrantees on budgeted travel	• Carry out subgrantee actions specified in B.1 above • Maintain a file documenting all travel expenses paid by Part B funds	Notice of Award
10. No use of Part B funds to pay any costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools), or to pay any amount expended by a State under Title XIX of Social Security Act	Implementation of actions specified in B.1 above	Carry out actions specified in B 1 above	Carry out subgrantee actions specified in B.1 above.	RW Part B 2615 (b)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Section C: **Income from Fees for Services Performed**				
1. Use of Part B and third party funds to maximize program income from third party sources and ensure that Ryan White is the payer of last resort. Third party funding sources include: • Medicaid • State Children's Health Insurance Programs (SCHIP) • Medicare (including the Part D prescription drug benefit) • Veteran's Administration, and • Private insurance (including medical, drug, dental and vision benefits)	• Information in client files that includes proof of screening for insurance coverage • Documentation of policies and consistent implementation of efforts to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance or other programs • Documentation of procedures for coordination of benefits by grantee and subgrantees	Establish and implement a process to ensure that subgrantees are maximizing third party reimbursements, including: • Requirement in subgrant agreement or through another mechanism that subgrantees maximize and monitor third party reimbursements • Requirement that subgrantees document in client files how each client has been screened for and enrolled in eligible programs • Monitoring to determine that Ryan White is serving as the payor of last resort, including review of client files and documentation of billing, collection policies and procedures, and information on third party contracts	• Have policies and staff training on the requirement that Ryan White be the payor of last resort and how that requirement is met • Require that each client be screened for insurance coverage and eligibility for third party programs, and helped to apply for such coverage, with documentation of this in client files • Carry out internal reviews of files and billing system to ensure that Ryan White resources are used only when a third party payor is not available • Establish and maintain medical practice management systems for billing	RW Part B 2617 (b(C) (iii) Funding Opportunity Announcement
2. Ensure billing and	• Inclusion in subgrant	• Include provisions in	Establish and consistently	Funding

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
collection from third party payers, including Medicare and Medicaid, so that payer of last resort requirements are met	agreements of language that requires billing and collection of third party funds • Review of the following subgrantee systems and procedures: o Billing and collection policies and procedures o Electronic or manual system to bill third party payors o Accounts receivable system for tracking charges and payments for third party payers	subgrant agreements that require billing and collection of third party funds • Where appropriate, require reports from subgrantees on collections from third party payers • Where the grantee is a provider of billable or pharmacy services, carry out same direct efforts as subgrantees	implement in medical offices and pharmacies: • Billing and collection policies and procedures • Billing and collection process and/or electronic system • Documentation of accounts receivable	Opportunity Announcement PHS Booklet Section 340 B Drug Pricing in Basic Language, Booklet 2
3. Subgrantee participation in Medicaid and certification to receive Medicaid payments required.	• Review of each subgrantee's individual or group Medicaid numbers • If subgrantee is not currently certified to receive Medicaid payments, documentation of efforts under way to obtain documentation and expected timing	• Maintain documentation of subgrantee Medicaid certification • Ensure that where subgrantees that are not certified maintain documentation of efforts under way to obtain documentation and expected timing.	• Document and maintain file information on grantee or individual provider agency Medicaid status • Maintain file of contracts with Medicaid insurance companies • If no Medicaid certification, document current efforts to obtain such certification If certification is not feasible, request a waiver where appropriate	Dr. Joseph F. O'Neill Letter 8/10/2000 RW Part A 2604 (g)(1-2), 2604 (h)(3)
4. Ensure billing, tracking, and reporting of program income	• Review of subgrantee billing, tracking, and reporting of program	• Monitor subgrantees to ensure appropriate billing and tracking of program	Bill, track, and report to the grantee all program income (including drug rebates) billed	45 CFR Part 74.14 45 CFR Part C 92.25

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
(including drug rebates) by grantee and subgrantees that provide reimbursable expenses	income, including drug rebates • Review of program income reported by the grantee in the FFR and annual reports	income, including drug rebates • Require subgrantee reporting of program income	and obtained	2 CFR Part C 215.24
5. Ensure service provider retention of program income derived from Ryan White-funded services and use of such funds in one or more of the following ways: • Funds added to resources committed to the project or program, and used to further eligible project or program objectives • Funds used to cover program costs ***Note:*** Program income funds are not subject to the federal limitations on administration (10%), quality management (5%), or core medical services (75% minimum). For example, all program income can be spent on administration of the Part B	• Review of grantee and subgrantee systems for tracking and reporting program income generated by Ryan White-funded services • Review of expenditure reports from subgrantees regarding collection and use of program income • Monitoring of medical practice management system to obtain reports of total program income derived from Ryan White Part B activities	• Monitor subgrantee receipt and use of program income to ensure use for program activities • Report aggregate program income in the FFR and annual data report • Provide a report detailing the expenditure of program income by each subgrantee	• Document billing and collection of program income. • Report program income documented by charges, collections, and adjustment reports or by the application of a revenue allocation formula	45 CFR 74.24 and 92.25 2 CFR Part C 215.24 Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
program, except in ADAP.				
Section D: **Imposition & Assessment of Client Charges**				
1. Unless waived, Ensure grantee and subgrantee policies and procedures that specify charges to clients for services, which may include a documented decision to impose only a nominal charge ***Note:*** This expectation applies to grantees that also serve as direct service providers and/or ADAP pharmacies	Review of subgrantee policies and procedures, to determine: • Existence of a provider sliding fee discount policy • Sliding fee discount schedule, based on current Federal Poverty Level (FPL) including cap on charges • Client applications for sliding fee discount • Actual client charges made and received • System used for charges, payments, and adjustments	• Require that subgrantees develop and then review: o Sliding fee discount policy and schedule o Eligibility criteria and sliding fee eligibility application form o Description of medical information system used to record patient charges, payments, and adjustments • Review documentation of subgrantee fee schedule, and narrative on agency medical information system to show that charges have been incurred • If providing direct services, meet same requirements as subgrantees	Establish, document, and have available for review: • Sliding fee discount policy • Current fee schedule • Sliding fee eligibility applications, in client files • Fees charged and paid by clients • Process for charging, obtaining, and documenting client charges through a medical practice information system manual or electronic	RW Part B 2617 (c)(1),(B) 2617 c (2)(A) Notice of Award
2. No charges imposed on clients with incomes below 100% of the Federal Poverty Level (FPL)	Review of provider sliding fee discount policy and schedule to ensure that clients with incomes below 100% of the FPL are not	• Review subgrantee sliding fee discount policy and schedule, criteria, and form to ensure that clients with incomes below 100% of	Document that: • Sliding fee discount policy and schedule do not allow clients below 100% of FPL to be charged for services	RW Part B 2617 (c) (1) (A)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Note: This standard applies to ADAP	charged for services, including ADAP services	the FPL are not to be charged for services • Review client files and documentation of actual charges and payments to ensure that the policy is being correctly and consistently enforced and clients below 100% of FPL are not being charged for services	• Personnel are aware of and following the policy and fee schedule • Policy is being consistently followed	
3. Charges to clients with incomes greater than 100% of poverty that are based on a discounted fee schedule and a sliding fee scale. Cap on total annual charges for Ryan White services (including ADAP) based on percent of patient's annual income, as follows: • 5% for patients with incomes between 100% and 200% of FPL • 7% for patients with incomes between 200% and 300% of FPL • 10% for patients with incomes greater than	• Review of policy, fee schedule, and cap on charges • Review of system for tracking patient charges and payments • Review of charges and payments to ensure that charges are discontinued once the patient has reached his/her annual cap	• Review subgrantee sliding fee scale/cap on charges policy and fee schedule, to ensure that they meet legislative requirements • Review system and records of charges and payments to ensure compliance with caps on charges • Review client files with sliding fee application forms to ensure consistency with policies and federal requirements	Have in place a fee discount policy that includes a cap-on-charges policy and appropriate implementation, including: • Clear responsibility for annually evaluating clients to establish individual fees and caps • Tracking of first Part B charges or medical expenses inclusive of enrollment fees, deductible, co-payments, etc. • A process for alerting the billing system that the client has reached the cap and should not be further charged for the remainder of the year • Documentation of policies,	RW Part B 2617 (c)(1)(C-E) RW Part B 2617 (c)(3)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
300% of FPL			fees, and implementation, including evidence that staff understand the policies and procedures	
Section E: **Financial Management**				
1. Compliance by grantee and subgrantees with all the established standards in the Code of Federal Regulations (CFR) for state and local governments, non-profit organizations, hospitals, and institutions of higher education. Included are expectations for: • Payments for services • Program income • Revision of budget and program plans • Non-federal audits • Property standards, including the purpose of insurance coverage, equipment, supplies, and other expendable property • Procurement standards,	• Review of grantee and subgrantee accounting systems to verify that they are sufficient and have the flexibility to operate the federal grant program and meet federal requirements • Review of the grantee's systems to ensure capacity to meet requirements with regard to: o Payment of subgrantee contractor invoices. o Allocation of expenses of subgrantees among multiple funding sources • Review of grantee and subgrantee: o Financial operations policies and	• Ensure access to and review: o Subgrantee accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports o All financial policies and procedures, including billing and collection policies and purchasing and procurement policies o Accounts payable systems and policies. • Ensure that subgrantee agreements require the availability of records for use by grantee auditors, staff, and federal government agencies • Include in subgrant	Provide grantee personnel access to: • Accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports of the subgrantee • All financial policies and procedures, including billing and collection policies and purchasing and procurement policies • Accounts payable systems and policies • ADAP Inventory and Local AIDS Pharmaceutical Assistance Program inventory	45 CFR 77 45 CFR 74 45 CFR 78 45 CFR 92 45 CFR 79 45 CFR 80 45 CFR 82

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
including recipient responsibilities, codes of conduct, competition, procurement procedures, cost and price analysis, and procurement records. • Reports and records, including monitoring and reporting, program performance, financial reports, and retention and access requirements • Termination and enforcement and purpose of closeout procedures	procedures o Purchasing and procurement policies and procedures o Financial reports • Review of subgrantee contract and correspondence files • Review of grantee's process for reallocation of funds by service category and subgrantee • Review of grantee's FFR trial worksheets and documentation	agreements required compliance with federal standards for financial management (45 CFR 72 & 94 or 2 CFR 215) • Review grantee financial systems to ensure the capacity for compliance with all federal regulations, including the FFR, and other required reporting, and make all systems and procedures accessible to federal funding and monitoring agencies		
2. Comprehensive grantee and subgrantee budgets and reports with sufficient detail to account for Ryan White funds by service category, subgrantee, administrative costs and Core medical and support services rule (75/25 rule), and to delineate between multiple funding sources and show program income	Review of: • Accounting policies and procedures • Grantee and subgrantee budgets • Accounting system used to record expenditures using the specified allocation methodology • Reports generated from the accounting system to determine if the detail and timeliness are sufficient to manage a Ryan White program	Determine the capacity of grantee and subgrantee: • Accounting policies and procedures • Budgets • Accounting system and reports to account for Part B funds in sufficient detail to meet Ryan White fiscal requirements	Ensure adequacy of agency fiscal systems to generate needed budgets and expenditure reports, including: • Accounting policies and procedures • Budgets • Accounting system and reports	Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
3. Line-item grantee and subgrantee budgets that include at least five category columns: • Administrative • Planning and Evaluation • Clinical Quality Management (CQM) • HIV Services • ADAP	• Review of grantee line- item budget and narrative for inclusion of required forms, categories, and level of detail to assess the funding to be used for administration, planning and evaluation, CQM, ADAP, and direct provision of services, and the budget's relation to the scope of services • Review of subgrantee line-item budget to ensure inclusion of required information and level of detail to ensure allowable use of funds and its relation to the proposed scope of services	• Use prescribed form SF-424A when submitting the line-item budget and budget justification • Include the following level of detail: o Salaries and fringe benefits for program staff o Contractual Services - personnel or services contracted to outside providers, for activities not done in-house o Administration- all funds allocated to the following grant activities: grantee administration, planning and evaluation, and quality management o ADAP - all funds allocated to the following grant activities: AIDS Drug Assistance Program o Consortia - all funds allocated to consortia and emerging communities o Direct Services- all funds allocated to the following grant activities:	Submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the propose services	CFR 74.12 45 CFR 92.10 2 CFR 215.25 Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		state direct services, home and community-based care, MAI, and health insurance continuation • Provide a Budget Justification narrative describing the uses, activities, and basis for the projections of Personnel Costs, Fringe Benefits, Travel, Equipment, Supplies, Contracts and Other to accompany the line-item budget o Develop provider Request for Proposals and subgrant agreement instructions for submission of provider line-item budgets		
4. Revisions to approved budget of federal funds that involve significant modifications of project costs made by the grantee only after approval from the HRSA/HAB Grants Management Officer (GMO)	• Comparison of grantee's current operating budget to the budget approved by the Project Officer • Documentation of written GMO approval of any budget modifications that exceeds the required threshold	• Where a budget modification requires HRSA/HAB approval, request the revision in writing to the Grants Management Officer (GMO) • Consider the approval official only when it has been signed by the GMO • Include in subgrantee	Document all requests for and approvals of budget revisions	45 CFR 74.25 45 CFR 92.30 2 CFR 215.25 (b) Notice of Award

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
A significant modification occurs under a grant where the federal share exceeds $100,000, when cumulative transfers among direct cost budget categories for the current budget period exceed 25% of the total approved budget (inclusive of direct and indirect costs and federal funds and required matching or cost sharing) for that budget period or $250,000, whichever is less. Even if a grantee's proposed re-budgeting of costs fall below the significant re-budgeting threshold identified above, grantees are still required to request prior approval, if some or all of the re-budgeting reflects either of the following: • A change in scope • A proposed purchase of a unit of equipment exceeding $25,000 (if not included in the approved application)		agreements specification of which budget revisions require approval, and provide written instructions on the budget revision process		
5. Provider subgrant agreements and other contracts that meet all	Development and review of Part B subgrant agreements and contracts to ensure	• Prepare subgrant agreements/contracts that meet both federal and local	• Establish policies and procedures to ensure compliance with subgrant	45 CFR 74.2 45 CFR 92.37 2 CFR 215.23

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
applicable federal and local statutes and regulations governing subgrant/contract award and performance Major areas for compliance: a. Follow state law and procedures when awarding and administering subgrants (whether on a cost reimbursement or fixed amount basis) b. Ensure that every subgrant includes any clauses required by Federal statute and executive orders and their implementing regulations c. Ensure that subgrant agreements specify requirements imposed upon subgrantees by federal statute and regulation d. Ensure appropriate retention of and access to records e. Ensure that any advances of grant funds to subgrantees	compliance with local and federal requirements	contracting requirements and provide specific clauses as stated in the Standard • Maintain file documentation of Part B subgrantee agreements/contracts and Award Letters • Revise subgrant agreements/contracts annually to reflect any changes in federal requirements Monitor compliance with subgrant provisions	provisions • Document and report on compliance as specified by the grantee	

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
substantially conform to the standards of timing and amount that apply to cash advances by federal agencies				
Section F: **Property Standards**				
1. Grantee and subgrantee tracking of and reporting on tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part B funds and having: • A useful life of more than one year, and • An acquisition cost of $5,000 or more per unit (Lower limits may be established, consistent with recipient policies)	Review to determine that the grantee and each subgrantee has a current, complete, and accurate: • Inventory list of capital assets purchased with Ryan White funds • Depreciation schedule that can be used to determine when federal revisionary interest has expired	• Develop and maintain a current, complete, and accurate asset inventory list and depreciation schedule • Ensure that each subgrantee maintains a current, complete, and accurate asset inventory list and depreciation schedule, and that they identify assets purchased with Ryan White funds	• Develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source • Make the list and schedule available to the grantee upon request	45 CFR 74.34 2 CFR 215.34 45 CFR 92.32 9(a)
2. Implementation of adequate safeguards for all capital assets that assure that they are used solely for authorized purposes	• Review of grantee and subgrantee inventory lists of assets purchased with Ryan White funds • During monitoring to ensure that assets are available and	• Carry out the actions specified in F.1 above • Ensure effective control over capital assets	Carry out the actions specified in F.1 above	45 CFR 74.30-37 45 CFR 92.30-37 2 CFR 215.30-37.

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	appropriately registered • Review depreciation schedule for capital assets for completeness and accuracy			
3. Real property, equipment, intangible property, and debt instruments acquired or improved with Federal funds held in trust by grantee and subgrantees, with title of the property vested in the grantee but with the federal government retaining a revisionary interest	• Implementation of actions specified in F.1 above • Review to ensure grantee and subgrantee policies that: o Acknowledge the revisionary interest of the federal government over property purchased with federal funds o Establish that such property may not be encumbered or disposed of without HRSA/HAB approval	• Carry out the actions specified in F.1 above • Ensure policies and procedures at grantee and subgrantee level stating that while title of property purchased with Ryan White Part B funds is vested in the grantee or subgrantee, the federal government will keep a revisionary interest • Ensure policies at the grantee and subgrantee level that establish that such property may not be encumbered or disposed of without the approval of HRSA/HAB as the HHS awarding agency	• Carry out the actions specified in F.1 above • Establish policies and procedures that acknowledge the revisionary interest of the federal government over property improved or purchased with federal dollars • Maintain file documentation of these policies and procedures for grantee review	45 CFR 74.32 45 CFR 92.31 2 CFR 215.32
4. Assurance by grantee and subgrantees that: • Title of federally-owned property remains vested in the federal government • If the HHS awarding agency has no further	Implementation of actions specified in F.1 above	Carry out the actions specified in F.1 above	Carry out the actions specified in F.1 above	45 CFR 74.33 45 CFR 92.33 2 CFR 215.33

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
need for the property, it will be declared excess and reported to the General Services Administration				
5. Title to supplies to be vested in the recipient upon acquisition, with the provision that if there is a residual inventory of unused supplies exceeding $5,000 in total aggregate value upon termination or completion of the program and the supplies are not needed for any other federally-sponsored program, the recipient shall: • Retain the supplies for use on non-federally sponsored activities or sell them • Compensate the federal government for its share contributed to purchase of supplies	Review to ensure the existence of an inventory list of supplies including medications purchased with local drug assistance or ADAP funds	• Develop and maintain a current, complete, and accurate supply and medication inventory list • Ensure that subgrantees develop and maintain similar lists and make them available to the grantee on request	• Develop and maintain a current, complete, and accurate supply and medication inventory list • Make the list available to the grantee upon request	45 CFR 74.35 45 CFR 92.36 2 CFR 215.35
Section G: **Cost Principles**				
1. Payments made to	Review grantee and	• Ensure that grantee	• Ensure that budgets and	2 CFR 230 or

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
subgrantees for services or drugs for treatment need to be cost based and relate to Ryan White administrative, quality management, and programmatic costs in accordance with standards cited under OMB Circulator the Code of Federal Regulation	subgrantee budgets and expenditure reports to determine whether use of funds is consistent with OMB and CFR cost requirements	expenses conform to federal cost principles for cost-reimbursable grants. • Ensure grantee and subgrantee staff familiarity with OMB-122 or Code of Federal Regulation (2CFR 230) requirements • Ensure that grantee and subgrantee budgets and expenditures conform to OMB and CFR requirements Include in subgrant agreements a provision requiring compliance with OMB cost principles	expenses conform to federal cost principles • Ensure fiscal staff familiarity with applicable federal regulations	OMB A-122 2 CFR Appendix A 225 D 1 (51912) or OMB-87
2. Payments made for services and drugs for treatment to be reasonable, not exceeding costs that would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs	• Review of subgrantee budgets and expenditure reports to determine costs and identify cost components • When applicable review of unit cost calculations for reasonableness • Review of fiscal and productivity reports to determine whether costs are reasonable when compared to level of service provided	• Submit reasonable and accurate budgets and annual expenditure reports • Assess the reasonableness of subgrantee costs by reviewing expenditures and unit cost calculations, looking with particular care at budgets and expenditure reports of subgrantee organizations or organizational divisions that receive most of their financial support from federal sources	• Make available to the grantee very detailed information on the allocation and costing out of expenses for services provided • Calculate unit costs based on historical data • Reconcile projected unit costs with actual unit costs on a yearly or quarterly basis •	2 CFR 230 OMB-122 Appendix A to Part 230 2 CFR A II 225 Appendix A C (2) 2 CFR 220 Appendix A (C) 3 or OMB A-21

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		• Review and keep on file he following documentation for each subgrantee: o Current budget o Unit cost agreement and calculation. • Fiscal and productivity reports		
3. Written grantee and subgrantee procedures for determining the reasonableness of costs, the process for allocations, and the policies for allowable costs, in accordance with the provisions of applicable Federal cost principles and the terms and conditions of the award Costs are considered to be reasonable when they do not exceed what would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs	• Review of policies and procedures that specify allowable expenditures for administrative costs and programmatic costs • Ensure reasonableness of charges to the Part B program	• Have in place policies to be used in determining allowable costs o Test to determine whether subgrantee costs for services as charged to the program are reasonable and allowable	• Have in place policies and procedures to determine allowable and reasonable costs • Have in reasonable methodologies for allocating costs among different funding sources and Ryan White categories • Make available policies, procedures, and calculations to the grantee on request	2 CFR 230 OMB A-122
4. Calculation of unit costs	• Review unit cost	Include in subgrantee	Have in place systems that	*Determining the*

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
by grantees and subgrantees to be based on an evaluation of reasonable cost of services or drug pricing; financial data must relate to performance data and to include development of unit cost information whenever practical ***Note:*** • When using unit costs for the purpose of establishing fee-for- service charges, the GAAP[2] definition can be used. Under GAAP, donated materials and services, depreciation of capital improvement, administration, and facility costs are allowed when determining cost. • If unit cost is the method of reimbursement, it can be derived by adding direct program costs and allowable administrative costs, capped at 10%,	methodology for subgrantee and provider services. • Review budgets to calculate allowable administrative and program costs for each service.	agreements a provision that requires submission of reports that detail performance and allow review of the subgrantee's: • Budget • Cost of services • Unit cost methodology.	can provide expenses and client utilization data in sufficient detail to determine reasonableness of unit costs	*Unit Cost of Services* (HRSA publication)

[2] GAAP = Generally Accepted Accounting Principles

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
and dividing by number of units of service to be delivered.				
5. Requirements to be met in determining the unit cost of a service: • Unit cost not to exceed the actual cost of providing the service • Unit cost to include only expenses that are allowable under Ryan White requirements • Unit cost for treatment drugs not to exceed 340 B prime vendor pricing and a reasonable dispensing fee Calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided	• Review methodology used for calculating unit costs of services provided • Review budgets to calculate allowable administrative and program costs for each service	• Review subgrantee unit cost methodology • Review grantee budget components to ensure that all expense categories are allowable under Ryan White	• Have in place systems that can provide expenses and client utilization data in sufficient detail to calculate unit cost • Have unit cost calculations available for grantee review	*Determining the Unit Cost of Services* (HRSA publication)
6. Requirement that States and Territories must secure the best price available for all products on their ADAP formularies.	Review of purchasing practices to assure the adoption by ADAP of at least one defined cost-saving practice that is equal to or better than 340 B drug	• Ensure that drug acquisition practices are compliant with federal requirements regarding cost-effectiveness and reasonableness	• Participate in 340 B Pricing Program • Use purchasing policies and procedures that meet federal requirements	NGA Part B CFR 42. Part 50 (e) Mr. Doug Morgan Letter 4/10/06

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
***Note**:* Failure to participate in cost-saving programs may result in a negative audit finding and cost disallowance	pricing or prime vendor program.	• Provide documentation of annual 340 B certification and/or Prime Vendor contract • Require subgrantees to be eligible for "covered entity status" under 340 B Pricing • Require subgrantees to have purchasing practices that meet federal requirements		Part B Manual 2003 Section 4 Chapter 1-3 Policy 97-04
7. Grantee to seek all available drug rebates and discounts ***Note:*** Drug rebates must not be treated as part of any Ryan White grant award and are not subject to the unobligated balance provision	• Verification that grantee has inquired or pursued obtaining of rebates and discounts • Review of budget for the expenditure of rebates funds • Review to determine whether expenditures meet HAB guidelines • Review of Financial Status Report for inclusion of rebates on SF 269 long form • Review of FFR to assure rebate funds are not included as part of the reported unobligated balance.	• Document any inquiry requesting medications rebates and discounts • Review report on drug rebates and discounts • Provide timely reports of rebates on FFR • Verify that rebates and discounts have not been use as grant funds. • Assure that rebates and discounts are not subject to the unobligated balance provision	N/A	RW Part B 2622 (d)(1) RW Part B 2616 (9)
8. Cost of health insurance or plans to be purchased or	• Verification that the grantee has conducted a cost analysis that show	Document a cost analysis demonstrating that the cost of health insurance or plans is	• Establish policies and procedures that ensure contract requirements are	RW Part B 2616 (f)(1-2)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
maintained not to exceed the cost of providing the drugs through ADAP	the use of health insurance or plans to be cost neutral or beneficial when compared to the cost of providing the treatment drugs through the ADAP program • If administration of the program is subcontracted, documentation that administrative costs are not excessive, federal requirements are being met, and process is accessible	lower than or equal to the cost of providing the drugs through ADAP • Document program requirements, client eligibility, allowable costs, and process for paying client premiums, co-pays, and deductibles • If the program is administered by an entity other than the State or Territory, include contract language that limits administration costs, clearly states reporting requirements, and requires assurances that legislative and programmatic requirements are being met	met • Provide detailed expense reports to enable the grantee document that costs are at or below the cost of providing the drugs through ADAP	HAB Policy Notice 99-01
Section H: **Auditing Requirements**				
1. Recipients and sub-recipients of Ryan White funds that are institutions of higher education or other non-profit organizations (including hospitals) are	Review requirements for subgrantee audits Review most recent audit (which may be an A-133 audit)to assure it includes: o List of federal grantees	• Include in subgrant agreement a requirement for a timely annual audit and associated management letter (an A- 133 audit if federal grants total more than $500,000)	• Conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds) • Request a management letter from the auditor • Submit the audit and	CFR 74.26 2 CFR 215.26 OMB A-133

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
subject to the audit requirements contained in the Single Audit Act Amendments of 1996 (31 USC 7501–7507) and revised OMB Circular A-133, with A-133 audits required for all grantees and subgrantees receiving more than $500,000 per year in federal grants	to ensure that the Ryan White grant is included o Programmatic income and expense reports to assess if the Ryan White grant is included • Review of audit management letter if one exists • Review of all programmatic income and expense reports for payer of last resort verification by auditor	• Maintain file documentation of subgrantee audits and management letters • Review audits to ensure inclusion of Ryan White funding • Review audit management letter to determine any material weaknesses • Review audit for income and expense reports testing of payer of last resort verification	management letter to the grantee • Prepare and provide auditor with income and expense reports that include payor of last resort verification	
2. Selection of auditor to be based on Audit Committee for Board of Directors (if nonprofit) policy and process	• Review of subgrantee financial policies and procedures related to audits and selection of an auditor	• Ensure financial policies and procedures in place for auditor selection • Ensure that subgrantees have policies and procedures in place to select an auditor	• Have in place financial policies and procedures that guide selection of an auditor • Make the policies and procedures available to grantee on request	CFR 74.26 2 CFR 215.26 45 CFR 92.26 OMB A-133
3. Review of audited financial statements to verify financial stability of organization	Review of Statement of Financial Position/Balance Sheet, Statement of Activities/Income and Expense Report, Cash flow Statement and Notes included in audit to determine organization's financial stability	Review subgrantee audited financial statements and notes to determine the organization's financial status and stability	• Comply with contract audit requirements on a timely basis • Provide audit to grantee on a timely basis	OMB A-133 and Audits for Non-profits
4. A-133 audits to include statements of	Review of statements of internal controls and federal	Annually review statements of internal controls and federal	• Comply with contract audit requirements on a timely	OMB A-133 and Audits for Non-

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
conformance with financial requirements and other federal expectations	compliance in A-133 audits	compliance in subgrantee A-133 audits to determine compliance with federal expectations	basis • Provide audit to grantee on a timely basis	profits
5. Grantees and subgrantees expected to note reportable conditions from the audit and provide a resolution.	• Review of reportable conditions • Determination of whether they are significant and whether they have been resolved • Development of action plan to address reportable conditions that have not been resolved	• Annually review subgrantee audits for reportable conditions • Obtain and review subgrantee agency responses to audit findings • Require corrective action if reportable conditions have not been resolved	• Comply with contract audit requirements on a timely basis • Provide grantee the agency response to any reportable conditions	OMB A-133 and Audits for Non-profits
6. State collection of audits from all Part B subgrantees within the State and submission of audits to the Secretary of Health and Human Services every two years, consistent with Office of Management and Budget Circular A-133	• Review to ensure that A-133 or other audits (where A-133 audits are not required) have been completed, collected, and submitted to HHS every two years	• Have documented evidence of grantee and subgrantees A-133 and other audits	• Comply with audit requirements	RW Part B 2617 (b)(4)(E)
Section I: **Matching or Cost-Sharing Funds**				
1. Grantees required to report to HRSA/HAB information regarding the	• Review grantee annual comprehensive budget • Review all grantee in-kind	• Report to HRSA/HAB on the non-federal funds or in- kind resources the State or	Where subgrantee on behalf of the grantee provides matching or cost sharing	45 CFR 92.24 2 CFR 215.27 45 CFR 74.23

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
portion of program costs that are not borne by the federal government Grantees expected to ensure that non-federal contributions (direct or through donations of private and public entities): • Are verifiable in grantee records • Are not used as matching for another federal program • Are necessary for program objectives and outcomes • Are allowable • Are not part of another federal award contribution (unless authorized) • Are part of the approved budget • Are part of unrecovered indirect cost (if applicable) • Are apportioned in accordance with appropriate federal cost principles • Include volunteer services, if used, that are	and other contributions to Ryan White program • Grantee documentation of other contributed services or expenses	Territory is allocating to the program • Ensure that the non-federal contribution meets all the requirements stated in the Standard in Column 1	funds, follow the same verification process as the grantee	RW Part B 2617(d)(1)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
an integral and necessary part of the program, with volunteer time allocated value similar to amounts paid for similar work in the grantee organization • Value services of contractors at the employees' regular rate of pay plus reasonable, allowable and allocable fringe benefits • Assign value to donated supplies that are reasonable and do not exceed the fair market value • Value donated equipment, buildings, and land differently according to the purpose of the award • Value donated property in accordance with the usual accounting policies of the recipient (not to exceed fair market value)				
2. Non-federal contributions by States and Territories that are equal to $1 for each $4	• Review of Part B application to determine that matching requirement for ADAP	• Provide to HRSA/HAB the information and documentation of required matching contribution.	• Where subgrantee on behalf of the grantee provides matching or cost sharing funds, follow the	RW Part B 2618(a)(2)(F)(ii)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
of federal ADAP supplemental funds and $1 for each $2 awarded under ADAP, unless a waiver is obtained	funds has been met • Review of grantee documentation of reported matching contributions	• Assure that matching contribution meets requirements stated in I.1 above	same verification process as the grantee	
3. Compliance with non-federal contribution requirements for Part B funding, which begin in the first year at $1 in State or Territory funds for every $45 in federal funds and increase to $1 in State or Territory funds for every $2 In Federal funds after Year 4 and thereafter	Review of records to verify that funds or in-kind expense reported as non-federal contribution are: • Non-federal • Allowable under relevant cost principles • Authorized by federal statute for cost sharing or matching • Provided in the Part B application • Meeting the mandated yearly ratio of non-federal to federal funds	• Provide a detailed list of funds or in-kind expense specified as the Part B match • Ensure that expenses claimed as part of the Part B are auditable	N/A	2617(d)(i)(A-E)
Section J: Maintenance of Effort				
1. Part B grantees are required to meet maintenance of effort (MOE) requirements: as a Condition of Award, the State or Territory expenditures for HIV-	• Review core medical services and support service budget elements that document the contributions of the State or Territory • Review tracking/	Submit the following MOE information to HRSA/HAB annually:: • A list of core medical and support services budget elements that will be used to document MOE in	N/A	RW Part B 2617 (b)(7)(E) Funding Opportunity Announcement Part B Manual

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
related core medical services and support services to be maintained at a level equal to their level during the one-year period preceding the fiscal year (FY) for which the grantee is applying for a Part B ***Note:*** States and Territories are required to: • Define consistency, • Define the methodology used, and • Maintain reported data consistently year to year	accounting system that documents the State or Territory's contribution to core medical services and supportive services • Review of grantee budget for State or Territory contributions • Review of actual tracking/accounting documentation of contributions	subsequent grant applications • A description of the tracking system that will be used to document these elements • Budget for State and Territorial contributions • Tracking/accounting documentation of actual contributions		2003 Section II 2
2. Use of Part B funds are used to supplement, not supplant, State or Territorial, EMA, or TGA funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease	Review of Maintenance of Effort (MOE) list and worksheet submitted with application stating the core medical services offered by the State or Territory to verify that Part B funds have not been used to fund these services during the grant year	Prepare and submit to HRSA/HAB required worksheet with sufficient detail to document the use of Part B funds to expand services and not to substitute funding for existing services	N/A	2617(d)(2)(A) Funding Opportunity Announcement Part B Manual II. Grants administration 2. MOE
Section K: **Fiscal Procedures**				

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
1. Grantee and subgrantee policies and procedures in place for handling revenues from the Ryan White grant, including program income	• Review policies and procedures related to the handling of cash or Ryan White grantee or subgrantee revenue • Sample accounting entries to verify that cash and grant revenue is being recorded appropriately	• Establish policies and procedures for handling Ryan White revenue • Prepare a detailed chart of accounts and general ledger that provide for the tracking of Part B revenue • Monitor policies and handling of Ryan White revenues by subgrantees	• Establish policies and procedures for handling Ryan White revenue including program income • Prepare a detailed chart of accounts and general ledger that provide for the tracking of Part B revenue • Make the policies and process available for grantee review upon request	OMB A-133
2. Advances of federal funds not to exceed 30 days and to be limited to the actual, immediate cash requirements of the program ***Note**:* Grantee permitted to draw down 1/12 of funds, but at the end of each month must do a reconciliation to actual expenses	• Review grantee's advance policy to assure it does not allow advances of federal funds for more than 30 days • Review subgrantee agreements for allowable advances • Review payments to subgrantees and payment management system draw-downs	• Provide expense documentation with every payment management system draw-down or reconciled PMS request to expenses on a monthly basis • Establish subgrant arrangements that limit advances of federal funding to 30 days • Document reconciliation of federal advances to subgrantees to submitted expenses	Document reconciliation of advances to actual expenses	45 CFR 74.22 (a)(2) 45 CFR 92.21 a 2
3. Right of the awarding agency to inspect and review records and documents that detail the programmatic and financial activities of	Review of subgrantee agreements to ensure that language is included that guarantees access to records and documents as required to oversee the	Include a provision in subgrantee agreements that guarantees grantee • access to subgrantee records and documents for program and fiscal	Have in place policies and procedures that allow the grantee as funding agency prompt and full access financial, program, and management records and	45CFR 74.61 (b)4(e) 45CFR 92.41

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
grantees and subgrantees in the use of Ryan White funds	performance of the Ryan White subgrantee	monitoring and oversight • Have in place policies and procedures that ensure HRSA/HAB similar access to grantee records and documents	documents as needed for program and fiscal monitoring and oversight	
4. Awarding agency to have access to payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White funds	Review of: • A sample of grantee and subgrantee payroll records • Grantee and subgrantee documentation that verifies that payroll taxes have been paid • Grantee and subgrantee accounts payable process, including a sampling of actual paid invoices with back-up documentation	• Maintain file documentation of payroll records and accounts payable, and hard-copy expenditures data • Include in subgrant agreements conditions that require the subgrantee to maintain and provide access to primary source documentation	• Maintain file documentation of payroll records and accounts payable, and hard-copy expenditures data • Make such documentation available to the grantee on request	45CFR 74.61 (b)4(e) 45 CFR 92.4
5. Awarding agency not to withhold payments for proper charges incurred by grantee unless the grantee or subgrantee has failed to comply with grant award conditions or is indebted to the United States; grantee not to withhold subgrantee payments unless subgrantee has	Review the timing of payments to subgrantees through sampling that tracks accounts payable process from date invoices are received to date checks are deposited	Periodically track the accounts payable process from date of receipt of invoices to date the checks are deposited	• Provide timely, properly documented invoices • Comply with contract conditions	45 CFR 74.22 2 CFR 215.22 9(h) (1-2)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
failed to comply with grant award conditions				
6. Awarding agency to make payment within 30 days after receipt of a billing, unless the billing is improperly presented or lacks documentation	• Review of grantee's payable records • Review of subgrantee invoices, submission dates, and bank deposits of Part B payments • Review of grantee policies on how to avoid payment delays of more than 30 days to subgrantees	• Establish and implement policies and procedures that allow for partial payments of invoices • Review reimbursement to subgrantees to determine whether it routinely occurs within 30 days of receipt of Invoice, and document delays due to incomplete documentation • Take action to improve reimbursement rates if review shows payment period of more than 30 days	• Submit invoices on time monthly, with complete documentation • Maintain data documenting reimbursement period, including monthly bank reconciliation reports and receivables aging report	2 CFR 215.22 (e)(4) Part C 45 CFR 92.21 45CFR 74.22
7. Employee time and effort to be documented, with charges for the salaries and wages of hourly employees • Be supported by documented payrolls approved by the responsible official • Reflect the distribution of activity of each employee • Be supported by records indicating the total number of hours worked	Review of documentation of employee time and effort, through: • Review of payroll records for specified employees • Documentation of allocation of payroll between funding sources if applicable	• Maintain payroll records for specified employees • Establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources	• Maintain payroll records for specified employees • Establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources • Make payroll records and allocation methodology available to grantee upon request	Fair Labor Standards Act (29 CFR 516) 2 CFR 230 Appendix B C.2 (d) 3 or OMB A-122

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
each day				
8. Applicants for Ryan White Part B funds will present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position	• Review grantee Staffing Plan • Review of Personnel section of grantee budget and related budget justification, including staff positions, education and experience qualifications, and rationale for the amount of time requested for each staff person	As part of application, provide: • Staffing Plan • Budget and budget justification, including staff positions, education and experience qualifications, and rationale for the amount of time requested for each staff person	N/A	Funding Opportunity Announcement
9. Grantee and subgrantee fiscal staff are responsible for: • Ensuring adequate reporting, reconciliation, and tracking of program expenditures • Coordinating fiscal activities with program activities *(For example, the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, formula and supplemental unobligated balances, and program income)*	• Review qualifications of program and fiscal staff • Review program and fiscal staff plan and full-time equivalents (FTEs) to determine if there are sufficient personnel to perform the duties required of the Ryan White grantee • Review of grantee organizational chart	• Prepare the following: o Program and fiscal staff resumes and job descriptions o Staffing Plan and grantee budget and budget justification o Grantee organizational chart • Require and review similar information for subgrant applicants	• Prepare the following: o Program and fiscal staff resumes and job descriptions o Staffing Plan and grantee budget and budget justification o Subgrantee organizational chart • Provide information to the grantee upon request	Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
• Having an organizational and communications chart for the fiscal department				
10. States and territories to submit an estimation of carryover funds 60 days prior to the end of the grant period – by January 31 of every calendar year	• Review of carryover request • Review of grantee accounting reports that document unobligated funds included in carryover request	• Prepare carryover request • Prepare accounting reports that document unobligated balances included in carryover request	N/A	Dr. Parham-Hopson Letter 12/5/07, Document 1023140429
Section L: **Unobligated Balances**				
1. State/Territory demonstration of its ability to expend fund efficiently by obligating and subsequently expending 95% of its formula funds in any grant year	• Review of grantee and subgrantee budgets • Review of grantee accounting and financial reports that document the year-to-date and year-end spending of grantee and subgrantee obligated funds, including separate accounting for formula and supplemental funds • Calculation of unspent funds and potential unspent funds to determine estimated	• Review both grantee and sub-grantee budgets • Maintain accounting and financial reports that document year-to-date spending of grantee and subgrantee funds • Review individual subgrantee financial reports that document unspent funds • Calculate year–to-date expenditures and budget variances monthly • Develop a reallocation	• Report expenditures to date promptly to the grantee every month • Inform the grantee of any situation that will make it impossible or unlikely to fully spend Part B subgrant funds	RW Part B 2622 (c)(4)(A)(i)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	unobligated balance	methodology and implement it (in coordination with Consortia if present)		
2. State/Territory annual unobligated balance for formula dollars of no more than 5% reported to HRSA/HAB in grantee's Federal Financial Report (FFR) ***Note:*** FFR must be submitted by July 30 following the end of the budget period with no exceptions	• Determination of the breakdown of the unobligated balance in the FFR by Formula, Supplemental, and Carryover • Submission of the final annual FFR no later than the July 30 after the closing of the grant year, without exception	• Track grant fund expenses by Formula, Supplemental, MAI and Carryover • Proactively track subgrantees' unspent funds • Establish a process to assure that the Finance Department of the political subdivision receiving the funds is aware of the importance of timely submission of an FFR and of spending formula dollars first • Proactively track the FFR submission and assure its reconciliation with the State or Territory's Formula, Supplemental, and carryover expenditures	• Provide timely reporting of unspent funds, position vacancies, etc. to the grantee • Establish and implement a process for tracking unspent Part A funds and providing accurate and timely reporting to the grantee	RW Part B 2620 (a)(2)
3. State or Territory recognition of consequences of unobligated balances and evidence of plans to avoid a reduction of services, if any of the following penalties is	• Review State or Territory compliance with any cancellation of unobligated funds • Review grantee and subgrantee budgets and implementation of plans in order to maintain	• Implement a cost-saving plan to address penalties resulting from excessive unobligated balance • Explore the possibility of requesting or using local dollars to offset any penalty to the program	• Report any unspent funds to the grantee • Carry out monthly monitoring of expenses to detect and implement cost- saving strategies	RW Part B 2622 (b) (1-2) HAB Policy notice 10-01

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
applied a. Future year award is offset by the amount of the unobligated balance b. Future year award is reduced by amount of unobligated balance less any approved carry over c. The grantee is not eligible for a future year supplemental award **Drug Rebates** The Unobligated balance provision does not apply to funds from drug rebated under Part B. By law, drug rebate amounts are not considered part of the grant award and are not subject to the unobligated balances provision. Rebate funds should never be recorded as unobligated balances on any FFR.	service levels during a penalty year			

HIV/AIDS Bureau, Division of Service Systems
Monitoring Expectations for Ryan White Part B Grantees:
Part B Program Monitoring Standards

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Section A: **Allowable Uses of Part B Service Funds**				
• Use of Part B funds only to support: • Core medical services • Support services that are	RFP and contract language that describes and defines Part B services within the range of activities and uses of funds	Include RFP and contract language that allows use of Part B funds only for the provision of services and	• Provide the services described in the RFP and contract • Bill only for allowable	RW Part B 2612 (a-d) RW Part B 2618

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needed by individuals with HIV/AIDS to achieve medical outcomes related their HIV/AIDS-related clinical status (***Note:*** All services provided through consortia are considered to be support services) c. Clinical quality management activities d. Planning and evaluation Part B base services shall be provided through the following Part B Components: • HIV Consortia • Home and community based care • Provision of treatments 3. State Direct Services	allowed under the legislation and defined in HRSA Policy Notices including core and support services, quality management activities, administration, and planning and evaluation	activities allowed under the legislation and defined in referenced Policy Notices	activities Maintain in files, and share with the grantee on request, documentation that only allowable activities are being billed to the Part B grant	(4-5) HAB Policy Notices 97-01, 97-02, and 10-02 and Dr. Parham-Hopson Letter 8/14/09, 4/8/10
Section B: **Core Medical-related Services**				RW Part B 2612 (b)(1)
1. Provision of **Outpatient and Ambulatory Medical Care,** defined as the provision of	Documentation of the following: • Care is provided by health care professionals certified	• Include the definition, allowable services, and limitations of outpatient ambulatory medical	• Ensure that client medical records document services provided, the dates and	RW Part B 2612 (b)(3)(A)

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professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with Public Health Service (PHS) guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies Allowable services include: • Diagnostic testing • Early intervention and risk assessment, • Preventive care and screening • Practitioner examination, medical history taking,	in their jurisdictions to prescribe medications in an outpatient setting such as a clinic, medical office, or mobile van • Only allowable services are provided • Services are provided as part of the treatment of HIV infection • Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects • Services are consistent with PHS guidelines • Service is not being provided in an emergency room, hospital or any other type of inpatient treatment center	services in the RFP and in provider contracts • Require subgrantees to provide assurances that care is provided only in an outpatient setting, is consistent with HRSA and PHS guidelines, and is chronicled in client medical records • Review client medical records to ensure compliance with contract conditions and Ryan White program requirements • Review the licensure of health care professionals providing ambulatory care	frequency of services provided, that service are for the treatment of HIV infection • Include clinician notes in patient records that are signed by the licensed provider of services • Maintain professional certifications and licensure documents and make them available to the grantee on request	

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diagnosis and treatment of common physical and mental conditions • Prescribing and managing of medication therapy • Education and counseling on health issues • Well-baby care • Continuing care and management of chronic conditions • Referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services)				
2. As part of Outpatient and Ambulatory Medical Care, provision of **laboratory tests** integral to the treatment of HIV infection and related complications	Documentation that tests are: • Integral to the treatment of HIV and related complications, necessary based on established clinical practice, and ordered by a registered, certified, licensed provider • Consistent with medical and laboratory standards • Approved by the Food and Drug Administration (FDA) and/or Certified under the	• Include the definition, requirements, and limitations of testing in medical services contract • Develop and share with providers a listing of laboratory tests that meet these definitions • Document the number of laboratory tests performed • Review client charts to ensure requirements are	Document, include in client medical records, and make available to the grantee on request: • The number of laboratory tests performed • The certification, licenses, or FDA approval of the laboratory from which tests were ordered • The credentials of the	HAB Policy Notice 07-02

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	Clinical Laboratory Improvement Amendments (CLIA) Program	met and match quantity of tests with reports	individual ordering the tests	
3. Funding allocated to a State-supported **AIDS Drug Assistance Program** (ADAP) that provides an approved formulary of medications to HIV-infected individuals for the treatment of HIV disease or the prevention of opportunistic infections, based on income guidelines	Documentation by the State of: • A medication formulary that includes pharmaceutical agents from all the classes approved in PHS Clinical Practice Guideliness for use of Antiretroviral Agents in HIV-1 infected Adults and Adolescents • A medication formulary that meets the minimum requirements from all approved classes of medications according to PHS treatment guidelines. • Policies and procedures that limit access, monitoring, and adherence to 5-10 percent of the	• Provide documentation that the ADAP program meets federal requirements, including: o Use of an approved medical formulary based on purchase of HIV medications included in the list of classes of core antiretroviral for eligible clients in a cost-effective manner • Use of medications that are FDA-approved • Use of Federal funds to match and expand the purchase of HIV medications and not displace State funding	• Provide to the Part B grantee, on request, documentation that the ADAP program meets HRSA/HAB requirements • Maintain documentation, and make available to the Part B grantee on request, proof of client ADAP eligibility that includes HIV status, residency, medical necessity, and low-income status as defined by the State based on a specified percent of the FPL	RW Part B 2612 (b)(3)(B) RW Part B 2616 HAB Policy Notice 00-02, HAB Policy Notice 07-03

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	State's total ADAP funding • An eligibility process requiring documentation in client medical records of low-income status and eligibility based on a specified percent of the Federal Poverty Level (FPL) and proof of an individual's HIV-positive status, residency, and the medical necessity for HIV related medications • A process used to secure the best price available for all products including 340B pricing or better	for the same purpose o Determination and documentation of client eligibility every six months • Require reporting on client eligibility, clients served, and medications provided ***Note**:* In cases where Consortium contributes to the State ADAP, the Consortium becomes a Part B provider and must provide documentation to the Part B Program to ensure allowable use of funds, report costs, and ensure client eligibility	• Provide reports to the Part B program of number of individuals served and the medications provided	
4. Implementation of a **Local AIDS Pharmaceutical Assistance Program** (LPAP) for the provision of HIV/AIDS medications using a drug distribution system that has: • A client enrollment and eligibility process • Uniform benefits for all enrolled clients throughout the	• Documentation that the (LPAP) program's drug distribution system has: • A client enrollment and eligibility process • Uniform benefits for all enrolled clients throughout the Consortium region • A recordkeeping system for distributed medications • A drug distribution	• Specify in the RFP and contract language all applicable federal, state, and local requirements for pharmaceutical distribution systems and the geographic area to be covered • Ensure that the program: o Meets federal requirements regarding client enrollment, uniform	• Provide to the Part B grantee, on request, documentation that the LPAP program meets HRSA/HAB requirements • Maintain documentation, and make available to the Part B grantee on request, proof of client LPAP eligibility that includes HIV status,	RW Part B 2612 (b)(3)(C) *HAB plans to issue future guidance regarding this service category.*

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Consortium region • A drug formulary approved by the local advisory committee/board • A recordkeeping system for distributed medications • A drug distribution system • A system for drug therapy management LPAP does not dispense medications as: • A result or component of a primary medical visit • A single occurrence of short duration (an emergency) • Vouchers to clients on an emergency basis A Program that is: • Consistent with the most current HIV/AIDS Treatment Guidelines • Coordinated with the State's Part B AIDS Drug Assistance Program • Implemented in accordance with	system that includes a drug formulary approved by the local advisory committee/board o A system for drug therapy management • Documentation that the LPAP is not dispensing medications as: • A result or component of a primary medical visit • A single occurrence of short duration (an emergency) without arrangements for longer term access to medication • Vouchers to clients on a single occurrence without arrangements for longer-term access to medications • Documentation that the LPAP Program is: • Consistent with the most current HIV/AIDS Treatment Guidelines • Coordinated with the State's Part B AIDS Drug Assistance Program • Implemented in accordance with	benefits, recordkeeping, and drug distribution process, consistency with current HIV/AIDS Treatment Guidelines o Defines the geographic area covered by the local pharmacy program, which must be either a TGA/EMA or consortium area • Does not dispense medication as the result of a primary care visit, in emergency situations or in the form of medication vouchers to clients on a single occurrence without arrangements for longer term access to medications • Review program records to ensure that distributed medications meet federal and contract requirements • Review client records to ensure proper enrollment, eligibility, uniform benefits, and no	residency, medical necessity, and low-income status as defined by the Consortium or State based on a specified percent of the Federal Poverty Level (FPL) • Provide reports to the Part B program of number of individuals served and the medications provided	

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requirements of the 340B Drug Pricing Program	requirements of 340B Drug Pricing Program	dispensing of medications for unallowable purposes		

5. Support for **Oral Health Services** including diagnostic, preventive, and therapeutic dental care that is in compliance with dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, is based on an oral health treatment plan, adheres to specified service caps, and is provided by licensed and certified dental professionals	Documentation that:
	• Oral health services are provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and meet current dental care guidelines
	• Oral health professionals providing the services have appropriate and valid licensure and certification, based on State and local laws
	• An oral health treatment plan is developed for each eligible client and signed by the oral health professional rendering the services
	• Services fall within specified service caps, expressed by dollar amount, type of procedure, limitations on the number of procedures, or a combination of any of the above, as determined by the grantee
		• Develop an RFP, contracts, and scopes of work for the provision of oral health that:
		  • Specify allowable diagnostic, preventive, and therapeutic services
		  • Define and specify the limitations or caps on providing oral health services
		  • Ensure that services are provided by dental professionals certified and licensed according to state guidelines
		• Review client charts for compliance with contract conditions and Ryan White program requirements such as service caps
		• Review treatment plans and services for compliance with contractual and Ryan White programmatic
			• Maintain a dental chart for each client that is signed by the licensed provider and includes a treatment plan, services provided, and any referrals made
			• Maintain, and provide to grantee on request, copies of professional licensure and certification
				RW Part B 2612 (b)(3)(D)

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		requirements		
6. Support of **Early Intervention Services** (EIS) that include identification of individuals at points of entry and access to services and provision of: • HIV Testing and Targeted counseling • Referral services • Linkage to care • Health education and literacy training that enable clients to navigate the HIV system of care All four components to be present, but Part B funds to be used for HIV testing only as necessary to supplement, not supplant, existing funding	Documentation that: • Part B funds are used for HIV testing only where existing federal, state, and local funds are not adequate, and Ryan White funds will supplement and not supplant existing funds for testing • Individuals who test positive are referred for and linked to health care and supportive services • Health education and literacy training is provided that enables clients to navigate the HIV system • EIS is provided at or in coordination with documented key points of entry • EIS services are coordinated with HIV prevention efforts and programs	Include RFP and contract language that: • Specifies that Part B funding is to be used to supplement and not supplant existing federal, state, or local funding for HIV testing • Provides definitions and models requiring that EIS services (funded through Ryan White or other sources) include and are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system • Specifies that services shall be provided at specific points of entry • Specifies required coordination with HIV prevention efforts and programs • Requires coordination	• Establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who test positive • Document provision of all four required EIS service components, with Part B or other funding • Document and report on numbers of HIV tests and positives, as well as where and when Part B-funded HIV testing occurs • Document that HIV testing activities and methods meet CDC and state requirements • Document the number of referrals for health care and supportive services • Document referrals from key points of entry to EIS programs	RW Part B 2612 (b)(3)(E) RW Part B 2612 (d) (1-2) *Additional policy guidance forthcoming, including expectations for Health education and literacy training, which are not covered in the legislation.*

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		with providers of prevention services • Requires monitoring and reporting on the number of HIV tests conducted and the number of positives found • Requires monitoring of referrals into care and treatment • Enables the grantee to modify targeting to include additional key points of entry	• Document training and education sessions designed to help individuals navigate and understand the HIV system of care • Establish linkage agreements with testing sites where Part B is not funding testing but is funding referral and access to care and education, system navigation services • Obtain written approval from the grantee to provide EIS services in points of entry not included in original scope of work	
7. Provision of **Health Insurance Premium and Cost-sharing Assistance** that provides a cost -effective alternative to ADAP by: • Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low income clients that provide a full	• Documentation of an annual cost-benefit analysis illustrating the greater benefit in purchasing public or private health insurance, pharmacy benefits, co-pays and or deductibles for eligible low income clients, compared to the costs of having the client in the ADAP program • Where funds are covering	Include RFP and contract language that: • Specify that Part B funding is to be used to supplement and not supplant existing federal, state, or local funding for Health Insurance Premium and cost- sharing assistance • Ensure an annual cost-benefit analysis that	• Conduct an annual cost benefit analysis (if not done by the grantee) that addresses noted criteria • Where premiums are covered by Ryan White funds, provide proof that the insurance policy provides comprehensive primary care and formulary with	RW Part B 2612 (b)(3)(F) RW Part B 2615 HAB Policy Notice 10-02 Affordable Care Act of 2010 Dr. Parham-Hopson Letter 3/15/2011

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range of HIV medications • Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of the client • Providing funds to contribute to a client's Medicare Part D true out-of-pocked (TrOOP) costs[1]	premiums, documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications • Where funds are used to cover co-pays for prescription eyewear, documentation including a physician's written statement that the eye condition is related to HIV infection • Assurance that any cost associated with the creation, capitalization, or administration of a liability risk pool is not being funded by Ryan White • Assurance that Ryan White funds are not being used to cover costs associated with Social Security • Documentation of clients' low income status as defined by the EMA/TGA or State Ryan White Program	includes an illustration of the greater benefit of using Ryan White funds for Insurance/Cost-Sharing Program versus having the client on ADAP • Documentation of the low income status of the client • Where funds are used to cover the costs associated with insurance premiums, ensure that comprehensive primary care services and a full range of HIV medications are available to clients • Provide in RFPs, scopes of work, and contract language clear directives on the payment of premiums, co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles in RFPs, scopes of work and contract language • Monitoring systems to check that funds are NOT	a full range of HIV medications to clients • Maintain proof of low-income status, • Provide documentation that demonstrates that funds were not used to cover costs associated with the creation, capitalization or administration of a liability risk pools, or social security costs • When funds are used to cover co-pays for prescription eyewear, provide a physician's written statement that the eye condition is related to HIV infection	

[1] Allowable use of Ryan White funds as of January 1, 2011 as specified in the Affordable Care Act.

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		being used for the creation, capitalization, or administration of liability risk pools, social security and or Medicare Part D costs including TrOOP or donut hole costs		
8. Support for **Home Health Care** services provided in the patient's home by licensed health care workers such as nurses; services to exclude personal care and to include: • The administration of intravenous and aerosolized treatment • Parental feeding • Diagnostic testing • Other medical therapies	Assurance that: • Services are limited to medical therapies in the home and exclude personal care services • Services are provided by home health care workers with appropriate licensure as required by State and local laws	• Include in the RFP and contract a clear definition of services to be provided and staffing and licensure requirements • Review client charts to determine compliance with contract conditions and Ryan White program requirements • Review licenses and certificates	• Document the number and types of services in the client records, with the provider's signature included • Maintain on file and provide to the grantee on request copies of the licenses of home health care workers	RW Part B 2612 (b)(3)(G)

9. Provision of **Home and Community-based Health Services,** defined as skilled health services furnished in the home of an HIV-infected individual, based on a written plan of care prepared by a case management team that includes appropriate	• Documentation that:
	  • All services are provided based on a written care plan signed by a case manager and a clinical health care professional responsible for the individual's HIV care and indicating the need for these services
	  • The care plan specifies
		• Specify in the RFP and contracts what services are allowable, the requirement that they be provided in the home of a client with HIV/AIDS, and the requirement for a written care plan signed by a case manager and a skilled health care professional responsible	• Ensure that written care plans with appropriate content and signatures are consistently prepared, included in client files, and updated as needed
			• Establish and maintain a program and client recordkeeping system to document the types
				RW Part B 2612 (b)(3)(J)
				
				RW Part B 2614

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health care professionals Allowable services to include: • Durable medical equipment • Home health aide and personal care services • Day treatment or other partial hospitalization services • Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy) • Routine diagnostic testing • Appropriate mental health, developmental, and rehabilitation services • Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities	the types of services needed and the quantity and duration of services o All planned services are allowable within the service category • Documentation of services provided that: • Specifies the types, dates, and location of services • Includes the signature of the professional who provided the service at each visit • Indicates that all services are allowable under this service category • Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community based health services Documentation of appropriate licensure and certifications for individuals providing the services, as required by local and state laws	for the individual's HIV care • Review program records and client files to ensure that treatment plans are prepared for all client and that they include: • Need for home and community-based health services • Types, quantity and length of time services are to be provided • Review client files to determine: • Services provided, dates, and locations • Whether services provided were allowable • Whether they were consistent with the treatment plan • Whether the file includes the signature of the professional who provided the service • Require assurance that the service is being provided in accordance with the type of locations	of home services provided, dates provided, the location of the service, and the signature of the professional who provided the service at each visit • Make available to the grantee program records and client files as required for monitoring • Provide assurance that the services are being provided only in an HIV-positive client's home • Maintain, and make available to the grantee on request, copies of appropriate licenses and certifications for professionals providing services	

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		allowable under the definition of Home and Community Based Health Services. Review licensure and certifications to ensure compliance with local and state laws • Give priorities in funding to entities that will assure participation in HIV care consortia where they exist and provide the service to low-income individuals		
10. Provision of **Hospice Care** provided by licensed hospice care providers to clients in the terminal stages of illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients Allowable services: • Room • Board • Nursing care	• Documentation including the following: o Physician certification that the patient's illness is terminal as defined under Medicaid hospice regulations (having a life expectancy of 6 months or less) o Appropriate and valid licensure of provider as required by the State in which hospice care is delivered o Types of services provided, and assurance that they include only allowable services	• Specify in RFP and contracts allowable services, service standards, service locations, and licensure requirements • Review provider licensure to ensure it meets requirements of State in which hospice care is delivered • Review program records and client files to ensure the following: o Physician certification of client's terminal status	• Obtain and have available for inspection appropriate and valid licensure to provide hospice care • Maintain and provide the grantee access to program records and client files that include documentation of • Physician certification of clients terminal status • Services provided and that they are allowable under Ryan White and in accordance with the	RW Part B 2612 (b)(3)(I) HAB Policy Notice 10-02

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• Mental health counseling • Physician services • Palliative therapeutics	o Locations where hospice services are provided, and assurance that they are limited to a home or other residential setting or a non-acute care section of a hospital designated and staffed as a hospice setting • Assurance that services meet Medicaid or other applicable requirements, including the following: • Counseling services that are consistent with the definition of mental health counseling, including treatment and counseling provided by mental health professionals (psychiatrists, psychologists, or licensed clinical social workers) who are licensed or authorized within the State where the service is provided • Palliative therapies that are consistent with those covered under the respective State's	• Documentation that services provided are allowable and funded hospice activities • Assurance that hospice services are provided in permitted settings • Assurance that services such as counseling and palliative therapies meet Medicaid or other applicable requirements	provider contract and scope of work • Locations where hospice services are provided include only permitted settings • Services such as counseling and palliative therapies meet Medicaid or other applicable requirements as specified in the contract	

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	Medicaid program			
11. Funding of **Mental Health Services** that include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers	• Documentation of appropriate and valid licensure and certification of mental health professionals as required by the State • Documentation of the existence of a detailed treatment plan for each eligible client that includes: o The diagnosed mental illness or condition • The treatment modality (group or individual) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date, • Any recommendations for follow up • The signature of the mental health professional rendering service • Documentation of service provided to ensure that: o Services provided are allowable under Ryan White guidelines and	• Specify in RFP and contracts allowable services and treatment modalities, staffing and licensure requirements, and requirements for treatment plans and service documentation • Review staffing and the licenses and certification of mental health professionals to ensure compliance with Ryan White and State requirements • Review program reports and client charts to: • Ensure the existence of a treatment plan that includes required components and signature • Document services provided, dates, and their consistency with Ryan White requirements and with the treatment plan	• Obtain and have on file and available for grantee review appropriate and valid licensure and certification of mental health professionals • Maintain program records documenting services provided • Maintain client charts that include: • A detailed treatment plan for each eligible client that includes required components and signature • Documentation of services provided, dates, and consistency with Ryan White requirements and with individual client treatment plans	RW Part B 2612 (b)(3)(K)

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	contract requirements o Services provided are consistent with the treatment plan			
12. Support for **Medical Nutrition Therapy** services including nutritional supplements provided outside of a primary care visit by a licensed registered dietitian; may include food provided pursuant to a physician's recommendation and based on a nutritional plan developed by a licensed registered dietitian	Documentation of: • Licensure and registration of the dietitian as required by the State in which the service is provided • Where food is provided to a client under this service category, client file that includes a physician's recommendation and a nutritional plan • Required content of the nutritional plan, including: o Recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food • Date service is to be initiated • Planned number and frequency of sessions • The signature of the registered dietitian who developed the plan • Services provided,	• Specify in RFP and contracts: • The allowable services to be provided • The requirement for provision of services by a licensed registered dietitian • The requirement for a nutritional plan and physician's recommendation where food is provided through this service category • The required content of the nutritional plan • Review program records and client files for: • Documentation of the licensure and registration of the dietitian providing services • Documentation of services provided, including the quantity and number of	• Maintain and make available to the grantee copies of the dietitian's license and registration • Document services provided, number of clients, and quantity of nutritional supplements and food provided to clients • Document in each client file: • Services provided and dates • Nutritional plan as required, including required information and signature • Physician's recommendation for the provision of food	RW Part B 2612 (b)(3)(H) HAB Policy Notice 10-02

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	including: • Nutritional supplements and food provided, quantity, and dates • The signature of each registered dietitian who rendered service, the date of service • Date of reassessment • Termination date of medical nutrition therapy • Any recommendations for follow up	recipients of nutritional supplements and food • Documentation of physician recommendations and nutritional plans for clients provided food • Content of the nutritional plan Documentation of medical nutritional therapy services provided to each client, compliance with Ryan White and contract requirements, and consistency of services with the nutritional plan		
13. Support for **Medical Case Management Services** (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care	• Documentation that service providers are trained professionals, either medically credentialed persons or other health care staff who are part of the clinical care team • Documentation that all the following activities are being carried out for all clients: • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Coordination of services	• Develop RFP and contracts that: • Clearly define medical case management services and activities and specify required activities and components • Specify required documentation to be included in client charts • Review client files and service documentation to ensure compliance with contractual and Ryan	• Provide written assurances and maintain documentation showing that medical case management services are provided by trained professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team • Maintain client charts that include the required elements for	RW Part B 2612 (b)(3)(M) HAB Policy Notice 10-02

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team, through all types of encounters including face-to-face, phone contact, and any other form of communication Activities that include at least the following: • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Coordination of services required to implement the plan • Continuous client monitoring to assess the efficacy of the plan • Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary Service components that may include: • A range of client- centered services that link clients with health care, psychosocial, and other services, including benefits/ entitlement	required to implement the plan • Continuous client monitoring to assess the efficacy of the plan • Periodic re-evaluation and adaptation of the plan at least every 6 months, during the enrollment of the client • Documentation in program and client records of case management services and encounters, including: • Types of services provided • Types of encounters/ communication • Duration and frequency of the encounters • Documentation in client records of services provided, such as: • Client-centered services that link clients with health care, psychosocial, and other services and assist them to access other public and private programs for which they may be eligible	White programmatic requirements, including inclusion of required case management activities • Review medical credentials and/or evidence of training of health care staff providing medical case management services • Obtain assurances and documentation showing that medical case management staff are operating as part of the clinical care team	compliance with contractual and Ryan White programmatic requirements, including required case management activities such as services and activities, the type of contact, and the duration and frequency of the encounter	

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counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services) • Coordination and follow up of medical treatments • Ongoing assessment of the client's and other key family members' needs and personal support systems • Treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments • Client-specific advocacy and/or review of utilization of services	• Coordination and follow up of medical treatments • Ongoing assessment of client's and other key family members' needs and personal support systems • Treatment adherence counseling • Client-specific advocacy			
14. Support for **Substance Abuse Treatment**	• Documentation that services are provided by or	• Develop an RFP and contracts that clearly	• Maintain and provide to grantee on request	RW Part B 2612 (b)(3)(L)

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Services-Outpatient, provided by or under the supervision of a physician or other qualified/licensed personnel; may include use of funds to expand HIV-specific capacity of programs if timely access to treatment and counseling is not otherwise available
 	
Services limited to the following:
• Pre-treatment/recovery readiness programs
• Harm reduction
• Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse
• Outpatient drug-free treatment and counseling
• Opiate Assisted Therapy
• euro-psychiatric pharmaceuticals
• Relapse prevention
• Limited acupuncture services with a written referral from the client's
	under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the State in which services are provided
	• Documentation through program records and client files that:
	  • Services provided meet the service category definition
	  • All services provided with Part A funds are allowable under Ryan White
	• Assurance that services are provided only in an outpatient setting
	• Assurance that Ryan White funds are used to expand HIV-specific capacity of programs only if timely access would not otherwise be available to treatment and counseling
	o Assurance that services provided include a treatment plan that calls for only allowable activities
		specify:
		• Allowable activities under this service category
		• The requirement that services be provided on an outpatient basis
		• The information that must be documented in each client's file
		• Review staff licensure and certification and staffing structure to ensure that services are provided under the supervision of a physician or other qualified/licensed personnel
		• Require assurance that services are provided on an outpatient basis
		• Review program records and client files for evidence of a treatment plan that specifies only allowable activities and includes:
		  • The quantity, frequency, and modality of treatment provided
		  • The date treatment
			documentation of:
			• Provider licensure or certifications as required by the State in which service is provided; this includes licensures and certifications for a provider of acupuncture services
			• Staffing structure showing supervision by a physician or other qualified personnel
			• Provide assurance that all services are provided on an outpatient basis
			• Maintain program records and client files that include treatment plans with all required elements and document:
			  • That all services provided are allowable under Ryan White
			  • The quantity, frequency and
				HAB Policy Notice 10-02

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primary health care provider, provided by certified or licensed practitioners wherever State certification or licensure exists • Services provided must include a treatment plan that calls only for allowable activities and includes: • The quantity, frequency, and modality of treatment provided • The date treatment begins and ends • Regular monitoring and assessment of client progress • The signature of the individual providing the service and or the supervisor as applicable	and includes: • The quantity, frequency, and modality of treatment provided • The date treatment begins and ends • Regular monitoring and assessment of client progress • The signature of the individual providing the service and or the supervisor as applicable • Documentation that • The use of funds for acupuncture services is limited through some form of defined cap • Acupuncture is not the dominant treatment modality • Acupuncture services are provided only with a written referral from the client's primary care provider • The acupuncture provider has appropriate State license and certification	begins and ends • Regular monitoring and assessment of client progress • The signature of the individual providing the service and or the supervisor as applicable o For any client receiving acupuncture services under this service category, documentation in the client file including: o Caps on use of Ryan White funds are in place • A written referral from their primary health care provider • Proof that the acupuncturist has appropriate certification or licensure, if the State provides such certification or licensure	modality of treatment services • The date treatment begins, and ends • Regular monitoring and assessment of client progress • The signature of the individual providing the service or the supervisor as applicable • In cases where acupuncture therapy services are provided, document in the client file: • A written referral from the primary health care provider • The quantity of acupuncture services provided • The cap on such services	

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***Section C:* Support Services**				
1. Use of Part B funds only for **Support Services** approved by the Secretary of Health and Human Services	Documentation that all funded support services are on the current list of HHS-approved support services	• Provide and contract for only HHS-approved support services • Monitor subgrantees to ensure that no Part B funds are used for non-allowable services categories	• Provide assurance to the grantee that Part B funds are being used only for support services approved by HHS	RW Part B 2612 (c)(1-2)
2. Support for **Case Management (Non-medical)** services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone	• Documentation that: • Scope of activity includes advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services • Where benefits/ entitlement counseling and referral services are provided, they assist clients in obtaining access to both public and private programs, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs,	f. Include in RFP, contracts, and scopes of work: • Clear statement of required and optional case management services and activities, including benefits/ entitlement counseling, • Full range of allowable types of encounters and communications g. Require in contract that client charts document at least the following: • Date of each encounter • Type of encounter (e.g., face-to-face, telephone contact, etc.) • Duration of encounter • Key activities	• Maintain client charts that include the required elements as detailed by the grantee, including: • Date of encounter o Type of encounter o Duration of encounter • Key activities, including benefits/ entitlement counseling and referral services • Provide assurances that any transitional case management for incarcerated persons meets contract requirements	Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 10-02

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contact, other) • Transitional case management for incarcerated persons as they prepare to exit the correctional system ***Note:*** Does not involve coordination and follow up of medical treatments	and other State or local health care and supportive services o Services cover all types of encounters and communications (e.g., face-to-face, telephone contact, other) • Where transitional case management for incarcerated persons is provided, assurance that such services are provided either as part of discharge planning or for individuals who are in the correctional system for a brief period	• Review client files and service documentation for compliance with contract requirements		
3. Funding for **Child Care Services** for the children of HIV-positive clients, provided intermittently, only while the client attends medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions May include use of funds to support: • A licensed or registered	• Documentation of: • The parent's eligibility as defined by the grantee, including proof of HIV status • The medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions attended by the parent that made child care services necessary • Appropriate and valid	• Develop RFPs, contracts and scopes of work as appropriate that clearly define child care services and allowable settings • Provide documentation that demonstrates that the grantee has clearly addressed the limitations of informal child care arrangements, including the issues of liability raised by such informal arrangements in child care and the appropriate	• Maintain documentation of: • Date and duration of each unit of child care service provided • Eligibility of client (HIV status, residence, and income eligibility) • Reason why child care was needed – e.g., client medical or other appointment or participation in a	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 10-02

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child care provider to deliver intermittent care • Informal child care provided by a neighbor, family member, or other person (with the understanding that existing Federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services) Such allocations to be limited and carefully monitored to assure: • Compliance with The prohibition on direct payments to eligible individuals • Assurance that liability issues for the funding source are carefully weighed and addressed through the use of liability release forms designed to protect the client, provider, and the Ryan White Program May include **Recreational and Social Activities** for	licensure and registration of child care providers under applicable State and local laws in cases where the services are provided in a day care or child care setting • Assurance that o Where child care is provided by a neighbor, family member, or other person, payments do not include cash payments to clients or primary caregivers for these services o Liability issues for the funding source are addressed through use of liability release forms designed to protect the client, provider, and the Ryan White Program o Any recreational and social activities are provided only in a licensed or certified provider setting	and legal releases from liability that cover the Ryan White Program and other federal, state and local entities as allowed by law • Require provider documentation that records the frequency, dates, and length of service, and type of medical or other appointment or Ryan White-related meeting, group, or training session that made child care necessary • Review provider documentation to ensure that child care is intermittent and is provided only to permit the client to keep medical and other appointments or other permitted Ryan White-related activities • Develop a mechanism for use with informal child care arrangements to ensure that no direct cash payments are made to clients or primary	Ryan White-related meeting, group, or training session o Any recreational and social activities, including documentation that they were provided only within a certified or licensed provider setting • Where provider is a child care center or program, make available for inspection appropriate and valid licensure or registration as required under applicable State and local laws • Where the provider manages informal child care arrangements, maintain and have available for grantee review: o Documentation of compliance with grantee-required mechanism for handling payments for informal child	

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the child, if provided in a licensed or certified provider setting including drop-in centers in primary care or satellite facilities • Excludes use of funds for off-premise social/recreational activities		caregivers • Document that any recreational and social activities are provided only within a licensed or certified provider setting	care arrangements • Appropriate liability release forms obtained that protect the client, provider, and the Ryan White program • Documentation that no cash payments are being made to clients or primary care givers • Documentation that payment is for actual costs of service	
4. Support for **Emergency Financial Assistance (EFA)** for essential services including utilities, housing, food (including groceries, food vouchers, and food stamps), or medications, provided to clients with limited frequency and for limited periods of time, through either: • Short-term payments to agencies • Establishment of voucher programs	Documentation of services and payments to verify that: • EFA to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the grantee • Assistance is provided only for the following essential services: utilities, housing, food (including groceries, food vouchers, and Food Stamps), or medications • Payments are made either through a voucher program	• Develop RFP and contracts that: • Define the allowable uses of EFA funds and the limitations of the program, including number/level of payments permitted to a single client • Require that Ryan White funds are used for EFA only as a last resort • Require providers to record and track use of EFA funds under each discrete service	• Maintain client records that document for each client: • Client eligibility and need for EFA • Types of EFA provided • Date(s) EFA was provided • Method of providing EFA • Maintain and make available to the grantee program documentation of assistance provided, including: • Number of clients	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notices 99-02, 97-01,97-02, 10-02

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Note: Direct cash payments to clients are not permitted	or short-term payments to the service entity, with no direct payments to clients • Emergency funds are allocated, tracked, and reported by type of assistance • Ryan White is the payer of last resort	category as required by the Ryan White Services Report (RSR) and Ryan White Data Report (RDR) • Review provider services and payment documentation to assure compliance with contractual and Ryan White programmatic requirements including: o Uses of funds • Methods of providing EFA payments • Use of Ryan White as payer of last resort • Specified limits on amounts and frequency of EFA to a single client	and amount expended for each type of EFA • Summary of number of EFA services received by client • Methods used to provide EFA (e.g., payments to agencies, vouchers) • Provide assurance to the grantee that all EFA: • Was for allowable types of assistance • Was used only in cases where Ryan White was the payer of last resort • Met grantee-specified limitations on amount and frequency of assistance to an individual client • Was provided through allowable payment methods	
5. Funding for **Food Bank/Home-delivered Meals** that may include: • The provision of actual	• Documentation that: o Services supported are limited to food bank, home-delivered meals,	• Develop RFP and contracts that specify: o What types of services are to be supported –	• Maintain and make available to grantee documentation of: o Services provided by	Funding Opportunity Announcement Dr. Parham-

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food items • Provision of hot meals • A voucher program to purchase food May also include the provision of non-food items that are limited to: • Personal hygiene products • Household cleaning supplies • Water filtration/ purification systems in communities where issues with water purity exist Appropriate licensure/ certification for food banks and home delivered meals where required under State or local regulations No funds used for: • Permanent water filtration systems for water entering the house • Household appliances • Pet foods Other non-essential products	and/or food voucher program • Types of non-food items provided are allowable • If water filtration/ purification systems are provided, community has water purity issues • Assurance of: • Compliance with federal regulations • Compliance with state and local regulations including any required licensure or certification for the provision of food banks and/or home-delivered meals • Use of funds only for allowable essential non-food items • Monitoring of providers to document actual services provided, client eligibility, number of clients served, and level of services to these clients	food bank, home-delivered meals, and/or food voucher program • Allowable and prohibited uses of funds for non-food items • Requirements for documenting services provided, client eligibility, and level and type of services provided to clients • Monitor providers to ensure: • Compliance with contractual requirements and with other federal, state, and local laws and regulations regarding food banks, home-delivered meals, and food voucher programs, including any required licensure and/or certifications • Verification that Ryan White funds are used only for purchase of allowable non-food	type of service, number of clients served, and levels of service • Amount and use of funds for purchase of non-food items, including use of funds only for allowable non-food items • Compliance with all federal, state, and local laws regarding the provision of food bank, home- delivered meals and food voucher programs, including any required licensure and/or certifications • Provide assurance that Ryan White funds were used only for allowable purposes and Ryan White was the payer of last resort	Hopson Letter 8/14/09 HAB Policy Notice 10-02

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		items		
6. Support for **Health Education/Risk Reduction** services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission Includes: • Provision of information about available medical and psychosocial support services • Education on HIV transmission and how to reduce the risk of transmission • Counseling on how to improve their health status and reduce the risk of HIV transmission to others	Documentation that clients served under this category: • Are educated about HIV transmission and how to reduce the risk of HIV transmission to others • Receive information about available medical and psychosocial support services • Receive education on methods of HIV transmission and how to reduce the risk of transmission • Receive counseling on how to improve their health status and reduce the risk of transmission to others	• Develop RFP and contracts that define risk reduction counseling and provide guidance on the types of information, education, and counseling to be provided to the client • Review provider data to: • Determine compliance with contract and program obligations • Ensure that clients have been educated and counseled on HIV transmission and risk reduction • Ensure that clients have been provided information about available medical and psychosocial support services	• Maintain, and make available to the grantee on request, records of services provided • Document in client charts: • Client eligibility • Information provided on available medical and psychosocial support services • Education about HIV transmission • Counseling on how to improve their health status and reduce the risk of HIV transmission	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09
7. Support for **Housing Services** that involve the provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or	• Documentation that funds are used only for allowable purposes: o The provision of short-term assistance to support emergency, temporary, or transitional	• Develop RFP and contracts that clearly define and specify allowable housing-related services, including housing-related referrals, types of housing, and	• Document: o Services provided including number of clients served, duration of housing services, types of housing provided,	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice

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family to gain or maintain medical care Use of funds for: • Housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services • Housing that does not provide direct medical or supportive services • Housing-related referral services that include assessment, search, placement, advocacy, and the fees associated with them No use of funds for direct payments to recipients of services for rent or mortgages ***Note:*** A 24-month cumulative cap on short-term and emergency housing assistance has been rescinded pending completion of a	housing to enable an individual or family to gain or maintain medical care • Housing-related referral services including housing assessment, search, placement, advocacy, and the fees associated with them • Housing that includes some type of medical or supportive services • Housing that does not include such services • Documentation that: • Each client receives assistance designed to help him/her obtain stable long-term housing, through a strategy to identify, re-locate, and/or ensure the individual or family is moved to or capable of maintaining a stable long-term living situation • No funds are used for direct payments to recipients of services for rent or mortgages	focus on short-term housing assistance • Review and monitor provider programs to: • Determine compliance with contract and program requirements • Ensure that housing referral services include housing assessment, search, placement, advocacy, and the fees associated with them • Ensure that clients receive assistance in obtaining stable long-term housing • Verify that no Ryan White funds are used for direct payment to clients for rent or mortgages	and housing referral services • Maintain client records that document: • Client eligibility • Housing services, including referral services provided • Assistance provided to clients to help them obtain stable long-term housing • Provide documentation and assurance that no Ryan White funds are used to provide direct payments to clients for rent or mortgages	99-02 Amendment 1 Federal Register Volume 75, Number 27

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comprehensive review of HRSA/HAB housing policy				
8. Funding for **Legal Services** provided for an HIV-infected person to address legal matters directly necessitated by the individual's HIV status May include such services as (but not limited to): • Preparation of Powers of Attorney and Living Wills • Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under Ryan White Permanency planning and for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS; includes the provision of social service counseling or legal counsel regarding (1) the drafting of	• Documentation that funds are used only for allowable legal services, which involve legal matters directly necessitated by an individual's HIV status, such as: • Preparation of Powers of Attorney and Living Wills • Services designed to ensure access to eligible benefits o • Assurance that program activities do not include any criminal defense or class-action suits unrelated to access to services eligible for funding under the Ryan White HIV/AIDS Program	• Develop RFP and contracts that clearly define allowable and non- allowable legal services and state the requirement that services must address legal matters directly necessitated by the individual's HIV status • Monitor providers to ensure that: • Funds are being used only for allowable services • No funds are being used for criminal defense or for class- action suits unless related to access to services eligible for funding under the Ryan White HIV/AIDS Program	• Document, and make available to the grantee upon request, services provided, including specific types of legal services provided • Provide assurance that: • Funds are being used only for legal services directly necessitated by an individual's HIV status • Ryan White serves as the payer of last resort • Document in each client file: • Client eligibility • A description of how the legal service is necessitated by the individual's HIV status • Types of services provided • Hours spent in the provision of such services	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 10-02

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wills or delegating powers of attorney, (2) preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption, Excludes: • Criminal defense • Class-action suits unless related to access to services eligible for funding under the Ryan White HIV/AIDS Program				

9. Support for **Linguistic Services** including interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of Ryan White-eligible services	• Documentation that:
	  • Linguistic services are being provided as a component of HIV service delivery between the provider and the client, to facilitate communication between the client and provider and the delivery of Ryan White-eligible services in both group and individual settings
	  • Services are provided by appropriately trained and qualified individuals holding appropriate State or local certification
		• Develop an RFP, contract, and scope of work that clearly describe: o The range and types of linguistic services to be provided, including oral interpretation and written translation as needed to facilitate communications and service delivery
		  • Requirements for training and qualifications based on available State and local certification
		• Monitor providers to assure that:
		  • Linguistic services are
			• Document the provision of linguistic services, including:
			  • Number and types of providers requesting and receiving services
			  • Number of assignments
			  • Languages involved
			  • Types of services provided – oral interpretation or written translation, and whether interpretation is for an individual client or a group
			• Maintain documentation
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		provided based on documented provider need in order for Ryan White clients to communicate with the provider and/or receive appropriate services o Interpreters and translators have appropriate training and State or local certification	showing that interpreters and translators employed with Ryan White funds have appropriate training and hold relevant State and/or local certification	
10. Funding for **Medical Transportation Services** that enable an eligible individual to access HIV-related health and support services, including services needed to maintain the client in HIV medical care, through either direct transportation services or vouchers or tokens May be provided through: • Contracts with providers of transportation services • Voucher or token systems • Use of volunteer drivers	• Documentation that: medical transportation services are used only to enable an eligible individual to access HIV-related health and support services • Documentation that services are provided through one of the following methods: • A contract or some other local procurement mechanism with a provider of transportation services • A voucher or token system that allows for tracking the distribution of the vouchers or tokens • A system of mileage	• Develop RFP and contracts that: • Clearly define medical transportation in terms of allowable services and methods of delivery • Require record keeping that tracks both services provided and the purpose of the service (e.g., transportation to/from what type of medical or support service appointment) • Specify requirements related to each service delivery method • Require that clients	• Maintain program records that document: o The level of services/number of trips provided • The reason for each trip and its relation to accessing health and support services • Trip origin and destination • Client eligibility • The cost per trip • The method used to meet the transportation need • Maintain documentation showing that the provider is meeting	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 10-02

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(through programs with insurance and other liability issues specifically addressed) • Purchase or lease of organizational vehicles for client transportation programs, provided the grantee receives prior approval for the purchase of a vehicle	reimbursement that does not exceed the federal per-mile reimbursement rates • A system of volunteer drivers, where insurance and other liability issues are addressed • Purchase or lease of organizational vehicles for client transportation, with prior approval from HRSA/HAB for the purchase	receive vouchers or tokens rather than direct payments for transportation services • Monitor providers to ensure that use of funds meets contract and program requirements	stated contract requirements with regard to methods of providing transportation: • Reimbursement methods do not involve cash payments to service recipients • Mileage reimbursement does not exceed the federal reimbursement rate • Use of volunteer drivers appropriately addresses insurance and other liability issues • Collection and maintenance of data documenting that funds are used only for transportation designed to help eligible individuals remain in medical care by enabling them to access medical and support services	

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11. Support for **Outreach Services** designed to identify individuals who do not know their HIV status and/or individuals who know their status and are not in care and help them to learn their status and enter care
 	
Outreach programs must be:
• Planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort
• Targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection
• Targeted to communities or local establishments that are frequented by individuals exhibiting high-risk behavior
• Conducted at times and in places where there is a high probability that individuals with HIV infection will be reached
• Designed to provide
	• Documentation that outreach services are designed to identify:
	  • Individuals who do not know their HIV status and refer them for counseling and testing
	  • Individuals who know their status and are not in care and help them enter or re-enter HIV- related medical care
	• Documentation that outreach services: o Are planned and delivered in coordination with local HIV prevention outreach programs and avoid duplication of effort
	  • Target populations known to be at disproportionate risk for HIV infection
	  • Target communities whose residents have disproportionate risk or establishments frequented by individuals exhibiting high-risk behaviors
	  • Are designed so that activities and results can
		• Develop RFP and contracts that:
		  • Provide a detailed description of the required scope and components of an outreach program, including whether it targets individuals who know and/or who do not know their HIV status
		  • Specify parameters to ensure that the program meets all HRSA/HAB requirements and guidance
		  • Require clearly defined targeting of populations and communities
		  • Require quantified reporting of individuals reached, referred for testing, found to be positive, referred to care, and entering care, to facilitate evaluation of effectiveness
		• Provide program
			• Document and be prepared to share with the grantee:
			  • The design, implementation, target areas and populations, and outcomes of outreach activities, including the number of individuals reached, referred for testing, found to be positive, referred to care, and entering care
			  • Data showing that all RFP and contract requirements are being met with regard to program design, targeting, activities, and use of funds
			• Provide financial and program data demonstrating that no outreach funds are being used:
			  • To pay for HIV counseling and testing
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quantified program reporting of activities and results to accommodate local evaluation of effectiveness ***Note:*** Funds may not be used to pay for HIV counseling or testing	be quantified for program reporting and evaluation of effectiveness • Documentation and assurance that outreach funds are not being used: o For HIV counseling and testing • To support broad-scope awareness activities that target the general public rather than specific populations and/or communities with high rates of HIV infection • To duplicate HIV prevention outreach efforts	monitoring and review for compliance with contract and program requirements and to ensure that funds are not being used: • For HIV counseling and testing • To support broad-scope awareness activities • To duplicate HIV prevention outreach efforts	• To support broad-scope awareness activities • To duplicate HIV prevention outreach efforts	
12. Support for **Psychosocial Support Services** that may include: • Support and counseling activities • Child abuse and neglect counseling • HIV support groups • Pastoral care/counseling • Caregiver support • Bereavement counseling • Nutrition counseling provided by a non-	• Documentation that psychosocial services funds are used only to support eligible activities, including: o Support and counseling activities • Child abuse and neglect counseling • HIV support groups • Pastoral care/counseling • Caregiver support • Bereavement counseling • Nutrition counseling provided by a non-	• Develop RFP and contracts that clearly specify: • The range and limitations of allowable services • Types of permitted pastoral care/ counseling • Monitor providers to ensure compliance with contract and program requirements • Provide assurance that:	• Document the provision of psychosocial support services, including: • Types and level of activities provided • Client eligibility • Maintain documentation demonstrating that: • Funds are used only for allowable services • No funds are used for provision of nutritional	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 10-02

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registered dietitian
 	
Note: Funds under this service category may not be used to provide nutritional supplements
 	
Pastoral care/counseling supported under this service category to be:
• Provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider)
• Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available
• Available to all individuals eligible to receive Ryan White services, regardless of their religious denominational
	registered dietitian
	• Documentation that pastoral care/counseling services meet all stated requirements:
	  • Provided by an institutional pastoral care program
	  • Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available
	  • Available to all individuals eligible to receive Ryan White services, regardless of their religious denominational affiliation
	  • Assurance that no funds under this service category are used for the provision of nutritional supplements
		• Funds are being used only for allowable services
		• No funds are being used for the provision of nutritional supplements
		• Funds for pastoral care/counseling met all stated requirements regarding the program, provider licensing or accreditation, and availability to all clients regardless of religious affiliation
			supplements
			o Any pastoral care/counseling services meet all stated requirements	

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affiliation				

13. Support for **Referral for Health Care/Supportive Services** that direct a client to a service in person or through telephone, written, or other types of communication, including the management of such services where they are not provided as part of Ambulatory/Outpatient Medical Care or Case Management services
 	
May include benefits/ entitlement counseling and referral to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services
 	
Referrals may be made:
	• Documentation that funds are used only:
	  • To direct a client to a service in person or through other types of communication
	  • To provide benefits/entitlements counseling and referral consistent with HRSA requirements
	  • To manage such activities
	  • Where these services are not provided as a part of Ambulatory/ Outpatient Medical Care or Case Management services
	• Documentation of:
	  • Method of client contact/communication
	  • Method of providing referrals (within the Non-medical Case Management system, informally, or as part of an outreach program)
	  • Referrals and follow up provided
		• Develop RFP and contracts to:
		  • Clearly specify allowable activities and methods of communication
		  • Specify that services may include benefits/ entitlements counseling and referral, and provide a definition and description of these services
		  • Clearly define the circumstances under which these activities may take place in order to avoid duplication with referrals provided through other service categories such as Non-medical Case Management
		  • Require documentation of referrals and follow up
		• Monitor providers to ensure compliance with contract and program
			• Maintain program records that document: o Number and types of referrals provided
			  • Benefits counseling and referral activities
			  • Number of clients served
			  • Follow up provided
			• Maintain client charts that include required elements as detailed by the grantee, including:
			  • Date of service
			  • Type of communication
			  • Type of referral
			  • Benefits counseling/referral provided
			  • Follow up provided
			• Maintain documentation demonstrating that services and circumstances of referral services meet contract requirements
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• Within the Non-medical Case Management system by professional case managers • Informally through community health workers or support staff • As part of an outreach program		requirements • Provide assurance that funds are not being used to duplicate referral services provided through other service categories		

14. Funding for **Rehabilitation Services:** Services intended to improve or maintain a client's quality of life and optimal capacity for self-care, provided by a licensed or authorized professional in an outpatient setting in accordance with an individualized plan of care
 	
May include:
• Physical and occupational therapy
• Speech pathology services
• Low-vision training
	• Documentation that services:
	  • Are intended to improve or maintain a client's quality of life and optimal capacity for self-care
	  • Are limited to allowable activities, including physical and occupational therapy, speech pathology services, and low-vision training
	  • Are provided by a licensed or authorized professional
	  • Are provided in accordance with an individualized plan of care that includes components specified by the grantee
		• Develop RFP and contracts that:
		  • Clearly define rehabilitation services and allowable activities
		  • Specify requirement for provision of services by a licensed or authorized professional in accordance with an individualized plan of care
		  • Specify where these activities may take place in order to avoid their provision in in- patient settings
		• Monitor providers to ensure compliance with contract and program requirements
		• Review program and
			• Maintain, and share with the grantee upon request, program and financial records that document:
			  • Types of services provided
			  • Type of facility
			  • Provider licensing
			  • Use of funds only for allowable services by appropriately licensed and authorized professionals
			• Maintain client charts that include the required elements as detailed by the grantee, including:
			  • An individualized plan of care
			  • Types of
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		client records to ensure that: o Client has a individualized plan of care that includes specified components o Services provided are in accordance with the plan of care	rehabilitation services provided (physical and occupational therapy, speech pathology, low-vision training) o Dates, duration, and location of services	
15. Support for **Respite Care** that includes non-medical assistance for an HIV-infected client, provided in community or home-based settings and designed to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV/AIDS ***Note:*** Funds may be used to support informal respite care provided issues of liability are addressed, payment made is reimbursement for actual costs, and no cash payments are made to clients or primary caregivers	• Documentation that funds are used only: • To provide non-medical assistance for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of that adult or minor • In a community or home-based setting • If grantee permits use of informal respite care arrangements, documentation that: • Liability issues have been addressed • A mechanism for payments has been developed that does not involve direct cash payment to clients or	• Develop RFP and contracts that: • Clearly define respite care including allowable recipients, services, and settings • Specify requirements for documentation of dates, frequency, and settings of services • If informal respite care arrangements are permitted, monitor providers to ensure that: o Issues of liability have been addressed in a way that protects the client, provider, and Ryan White program • A mechanism is in place to ensure that no cash payments are	• Maintain, and make available to the grantee on request, program records including: • Number of clients served • Settings/methods of providing care • Maintain in each client file documentation of: o Client and primary caretaker eligibility • Services provided including dates and duration • Setting/method of services • Provide program and financial records and assurances that if informal respite care arrangements are used:	Funding Opportunity Announcement HAB Policy Notice 10-02

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	primary caregivers o Payments provide reimbursement for actual costs without over payment, especially if using vouchers or gift cards	made to clients or primary caregivers o Payment made is for reimbursement of actual costs, especially if using vouchers or gift cards	• Liability issues have been addressed, with appropriate releases obtained that protect the client, provider, and Ryan White program • No cash payments are being made to clients or primary caregivers • Payment is reimbursement for actual costs	
16. Funding for **Substance Abuse Treatment – Residential** to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a short-term residential health service setting Requirements: • Services to be provided by or under the supervision of a physician or other qualified personnel with	• Documentation that: • Services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the State in which services are provided • Services provided meet the service category definition • Services are provided in accordance with a	• Develop RFP and contracts that clearly specify: • Allowable activities under this service category • The requirement that services be provided in a short-term residential health service setting • Limitations and permitted use of acupuncture • Requirements for a treatment plan including specified	• Maintain, and provide to grantee on request, documentation of: • Provider licensure or certifications as required by the State in which service is provided; this includes licensures and certifications for a provider of acupuncture services • Staffing structure showing supervision by a physician or	Funding Opportunity Announcement HAB Policy Notice 10-02

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appropriate and valid licensure and certification by the State in which the services are provided • Services to be provided in accordance with a treatment plan • Detoxification to be provided in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of a hospital) • Limited acupuncture services permitted with a written referral from the client's primary health care provider, provided by certified or licensed practitioners wherever State certification or licensure exists	written treatment plan • Assurance that services are provided only in a short- term residential setting • Documentation that if provided, acupuncture services: • Are limited through some form of defined financial cap • Are provided only with a written referral from the client's primary care provider • Are offered by a provider with appropriate State license and certification if it exists	elements • What information that must be documented in each client's file • What information is to be reported to the grantee • Review staff licensure and certification and staffing structure to ensure that services are provided under the supervision of a physician or other qualified/licensed personnel • Require assurance that services are provided in a short-term residential setting • Monitor provider and review program records and client files for evidence of a treatment plan with the required components • For any client receiving acupuncture services under this service category, documentation in the client file including: o Caps on use of Ryan White funds	other qualified personnel • Provide assurance that all services are provided in a short-term residential setting • Maintain program records that document: o That all services provided are allowable under this service category • The quantity, frequency, and modality of treatment services • Maintain client files that document: • The date treatment begins and ends • Individual treatment plan • Evidence of regular monitoring and assessment of client progress • In cases where acupuncture therapy services are provided, document in the client file: • A written referral	

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		• A written referral from their primary health care provider • Proof that the acupuncturist has appropriate certification or licensure, if the State provides such certification or licensure	from the primary health care provider o The quantity of acupuncture services provided	
17. Support for **Treatment Adherence Counseling,** which is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments, provided by non-medical personnel outside of the Medical Case Management and clinical setting	Documentation that services provided under this category are: • Designed to ensure readiness for, and adherence to, complex HIV/AIDS treatments • Provided by non-medical personnel • Provided outside of the Medical Case Management and clinical setting	• Develop RFP and contracts that clearly specify: • Allowable activities under this service category • The requirement that services be provided by non-medical personnel • The requirement that services be provided outside of the Medical Case Management and clinical setting • The information that must be documented in each client's file and reported to the grantee • Monitor provider and review client records to	• Provide assurances and maintain documentation that: o Services provided are limited to those permitted by the contract • Services are provided by non-medical personnel • Services are provided outside the Medical Care Management and clinical setting • Maintain client charts that include the required elements as detailed by the grantee	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		ensure compliance with contractual and program requirements		
Section D: **Quality Management**				
1. Implementation of a **Clinical Quality Management (CQM) Program** to: • Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infections • Develop strategies for ensuring that services are consistent with the guidelines for improvement in the access to and quality of HIV health services CQM program to include: • A Quality Management Plan • Quality expectations for	• Documentation that the Part B Program has in place a Clinical Quality Management Program that includes, at a minimum: o A Quality Management Plan o Quality expectations for providers and services o A method to report and track expected outcomes o Monitoring of provider compliance with HHS treatment guidelines and the Part B Program's approved standards of care for each funded service category • Review of CQM program to ensure that both the grantee and providers are carrying out necessary CQM activities and reporting CQM performance data	• Develop, implement, and monitor progress towards a Quality Management Plan • Specify in RFPs and provider contracts the grantee's quality-related expectations for each service category • Conduct chart reviews and visits to subgrantees to monitor compliance with the Quality Management Plan and with Ryan White quality expectations • Provide a written Assurance signed by the Chief Elected Official that the Quality Management Program meets HRSA requirements	Participate in quality management activities as contractually required; at a minimum: • Compliance with relevant service category standards of care • Collection and reporting of data for use in measuring performance	RW Part B 2618 (b)(3)(C&E)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
providers and services • A method to report and track expected outcomes • Monitoring of provider compliance with HHS treatment guidelines and the Part B Program's approved Standards of Care • *The State will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under the Part B Program*				
Section E: **Administration**				
1. **Administration:** Grantees to spend no more than 10% percent of grant funds on planning and evaluation activities, not more than 10% on administration and, when combined, not more than 15% on planning, evaluation and	• Documentation that grantee administrative costs paid by Part B funds, including planning and evaluation costs, are not more than 15% of total grant funds • Review of activities to ensure the proper categorization of allowable administrative functions	• Document, through job descriptions and time and effort reports, that the activities defined in the legislation and guidance as administration are charged to administration of the program and cost no more than 10% of the total grant amount • Document that no		Notice of Award RW Part B 2618 (b)(2-4) Part B Manual Section II, Chapter 5

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administration ***Notes:*** • An exception is allowed for those States that receive a minimum allotment under the Part B formula; they are limited to spending not more than the amount required to support one full-time equivalent employee • This 15% limitation does not include the up to 5% of funds that may be spent on clinical quality management activities Administrative funds to be used for routine grant administration and monitoring activities, including: • Planning and evaluation • Preparation of routine programmatic and financial reports • Compliance with grant conditions and audit requirements • Activities associated with		activities defined as administrative in nature are included in other Part B budgets • Provide HRSA/HAB with current operating budgets that include sufficient detail to review administrative expenses		

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
the grantee's contract award procedures including: • The development of requests for proposals (RFPs) • Drafting, negotiation, awarding, and monitoring of contract awards • The development of the applications for Part B funds • The receipt and disbursal of program funds • The development and establishment of reimbursement and accounting systems • Funding re-allocation • Planning body operations and support ***Note***: Please see Part B Fiscal Monitoring Standards, especially Section A, for additional information on use of funds for administration				
Section F: **Other Service Requirements**				
1. **WICY – Women,**	• Documentation that the	• Track and report the	Track and report to the	Dr. Joseph F.

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Infants, Children, and Youth: Amounts set aside for women, infants, children, and youth to be determined based on each of these population's relative percentage of the total number of persons living with AIDS in the State Waiver available if grantee can document that funds sufficient to meet the needs of these population groups are being provided through other federal or state programs	amount of Part B funding spent on services for women, infants, children, and youth is at least equal to the proportion each of these populations represents of the entire population of persons living with AIDS in the State d. If a waiver is requested, documentation that the service needs of one or more of these populations are already met through funding from another federal or state program	amount and percentage of Part B funds expended for each priority population separately • Demonstrate that expenditures for each priority population meet or exceed the ratio of reported cases for that specific population to the total AIDS population • Apply for a waiver for one or more of the designated populations if needed care is provided through other federal/state programs	grantee the amount and percentage of Part B funds expended for services to each priority population	O'Neill Letter 8/10/2000 Mr. Doug Morgan Letter 6/17/03
2. **Referral relationships with key points of entry:** Requirement that Part B service providers maintain appropriate referral relationships with entities that constitute key points of entry Key points of entry defined in legislation: • Emergency rooms • Substance abuse and mental health treatment	Documentation that written referral relationships exist between Part B service providers and key points of entry	• Require in RFPs and contracts that providers establish written referral relationships with defined key points of entry into care • Review subcontractors' written referral agreements with specified points of entry • Review documented client files to determine whether referral relationships are being	• Establish written referral relationships with specified points of entry • Document referrals from these points of entry	RW Part B 2617 (b)(7)(G)

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programs • Detoxification centers, • Detention facilities • Clinics regarding sexually transmitted disease • Homeless shelters • HIV disease counseling and testing sites • Health care points of entry specified by eligible areas • Federally Qualified Health Centers • Entities such as Ryan White Part C and D grantees		used		
Section G: **Prohibition on Certain Activities**				
1. **Drug Use and Sexual Activity:** Ryan White funds cannot be used to support AIDS programs or materials designed to promote or directly encourage intravenous drug use or sexual activity, whether homosexual or heterosexual	• Signed contracts, grantee and subgrantee assurances, and/or certifications that define and specifically forbid the use of Ryan White funds for unallowable activities • Grantee review of subgrantee budget and expenditures to ensure that they do not include any unallowable costs or activities	• Include definitions of unallowable activities in all subgrantee RFPs, subgrantee agreements, purchase orders, and requirements or assurances • Include in financial monitoring a review of subgrantee expenses to identify any unallowable costs • Require subgrantee	• Maintain a file with signed subgrantee agreement, assurances, and/or certifications that specify unallowable activities • Ensure that budgets and expenditures do not include unallowable activities • Ensure that expenditures do not	Notice of Award RW Part E 2684

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		budgets and expense reports with sufficient budget justification and expense detail to document that they do not include unallowable activities	include unallowable activities • Provide budgets and financial expense reports to the grantee with sufficient detail to document that they do not include unallowable costs or activities	
2. **Purchase of Vehicles without Approval:** No use of Ryan White funds by grantees or subgrantees for the purchase of vehicles without written approval of HRSA Grants Management Officer (GMO)	• Implementation of actions specified in G.1 above • Where vehicles were purchased, review of files for written permission from GMO	• Carry out actions specified in G.1 above • If any vehicles were purchased, maintain file documentation of permission of GMO to purchase a vehicle	• Carry out subgrantee actions specified in G.1 above • If vehicle purchase is needed, seek grantee assistance in obtaining written GMO approval and maintain document in file	Notice of Award HAB Policy Notice 10-02
3. **Broad Scope Awareness Activities:** No use of Ryan White funds for broad scope awareness activities about HIV services that target the general public	• Implementation of actions specified in G.1 above • Review of program plans, budgets, and budget narratives for marketing, promotions and advertising efforts, to determine whether they are appropriately targeted to	• Carry out actions specified in G.1 above • Review program plans and budget narratives for any marketing or advertising activities to ensure that they do not include unallowable activities	• Carry out subgrantee actions specified in G.1 above • Prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities	Notice of Award HAB Policy Notice 07-06

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	geographic areas and/or disproportionately affected populations rather than targeting the general public			
4. **Lobbying Activities:** Prohibition on the use of Ryan White funds for influencing or attempting to influence members of Congress and other Federal personnel	• Implementation of actions specified in G.1 above • Review of lobbying certification and disclosure forms for both the grantee and subgrantees ***Note:*** Forms can be obtained from the CFR website: http://www.hhs.gov/forms/PHS-5161-1.pdf http://ecfr.gpoAccess.gov	• Carry out actions specified in G.1 above • File a signed "Certification Regarding Lobbying", and, as appropriate, a "Disclosure of Lobbying Activities" • Ensure that subgrantee staff are familiar and in compliance with prohibitions on lobbying with federal funds	• Carry out subgrantee actions specified in G.1 above • Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds	45 CFR 93 Conditions of Grant Award Dr. Parham-Hopson Letter 2/3/09
5. **Direct Cash Payments:** No use of Ryan White program funds to make direct payments of cash to service recipients	• Implementation of actions specified in G.1 above • Review of Standards of Care and other policies and procedures for service categories involving payments made on behalf of individuals to ensure that no direct payments are made to individuals (e.g., emergency financial assistance, transportation, health insurance premiums, medical or medication co- pays and deductibles, food	• Carry out actions specified in G.1 above • Ensure that Standards of Care for service categories involving payments made on behalf of clients forbid cash payments to service recipients	• Carry out subgrantee actions specified in G.1 above • Maintain documentation of policies that forbid use of Ryan White funds for cash payments to service recipients	RW Part B 2618 (b)(6) HAB Policy Notice 10-02

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	and nutrition) • Review of expenditures by subgrantees to ensure that no cash payments were made to individuals			
6. **Employment and Employment-Readiness Services:** Prohibition on the use of Ryan White program funds to support employment, vocational, or employment-readiness services	Implementation of actions specified in G.1 above	Carry out actions specified in G.1 above	Carry out subgrantee actions specified in G.1 above	HAB Policy Notice 10-02
7. **Maintenance of Privately Owned Vehicle:** No use of Ryan White funds for direct maintenance expenses (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees ***Note:*** This restriction does not apply to vehicles operated by organizations for program purposes	• Implementation of actions specified in G.1 above • Documentation that Ryan White funds are not being used for direct maintenance expenses or any other costs associated with privately owned vehicles, such as lease or loan payments, insurance, or license and registration fees – except for vehicles operated by organizations for program purposes	• Carry out actions specified in G.1 above • Clearly define the prohibition against expenditures for maintenance of privately owned vehicles in RFPs and contracts, including clarification of the difference between privately owned vehicles and vehicles owned and operated by organizations for program purposes	• Carry out subgrantee actions specified in G.1 above	HAB Policy Notice 10-02

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8. Syringe Services: No use of Ryan White funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drugs.	• Implementation of actions specified in G.1 above • Documentation that Ryan White funds are not being used for programs related to sterile needles or syringe exchange for injection drug use.	• Carry out actions specified in G.1 above • Clearly define the prohibition against the expenditures for syringe and sterile needle exchange in RFPs and contracts	• Carry out subgrantee actions specified in G.1 above	Consolidated Appropriations Act 2012, Division F, Title V, Sec. 523 Ronald Valdiserri Letter 3/29/2012
9. **Additional Prohibitions:** No use of Ryan White Funds for the following activities or to purchase these items: • Clothing • Funeral, burial, cremation or related expenses • Local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied) • Household appliances • Pet foods or other non-essential products • Off-premise social/recreational activities or payments for	• Implementation of actions specified in G.1 above • Review and monitoring of grantee and subgrantee activities and expenditures to ensure that Ryan White funds are not being used for any of the prohibited activities	• Carry out actions specified in G.1 above • Develop and implement a system to review and monitor subgrantee program activities and expenditures and ensure a similar system to review and monitor grantee expenditures	• Carry out subgrantee actions specified in G.1 above	HAB Policy Notice 10-02 Service RW Part B 2618 (b)(6) Dr. Parham-Hopson Letter 12/2/10

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a client's gym membership • Purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility • Pre-exposure prophylaxis				
Section H: **Chief Elected Official (CEO) Agreements & Assurances**				
1. **Planning:** a. Establishment of a public advisory process, including public hearings, that involves mandated participants and allows comment on the development and implementation of the comprehensive plan. participants to include individuals with HIV/AIDS, members of a Federally recognized Indian tribe as represented in the	Documentation that the CEO has established a public advisory process involving the participants specified in the legislation and that it is providing comments on the development and implementation of the comprehensive plan	Ensure the CEO understands the role of the public advisory process, the membership requirements, and the responsibility for input into the comprehensive plan and its implementation	N/A	RW Part B 2617 (b)(7)(A)

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State, representatives of grantees under each part under this title, providers, and public agency representatives				
b. Maintenance of appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating early intervention services for HIV-positive individuals	Documentation of written referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating early intervention services for individuals diagnosed as being HIV-positive	• Work with consortia, service providers, and individuals with HIV/AIDS to identify key points of entry using needs assessment process • Require development and maintenance of written referral and linkage agreements between Ryan White providers and key points of entry • Monitor the use of referral and linkage agreements by funded providers	• Obtain written referral and linkage agreements with key points of entry, and make these agreements available for review by the grantee upon request • Develop a mechanism to track referrals from these key points of entry and linkages to care	RW Part B 2617 (b)(7)(G)
c. Provision of Part B-funded HIV primary medical care and support services, to the maximum extent possible, without regard to either: • The ability of the individual to pay for such services, or • The current or past	• Documentation that the EMA/TGA is funding HIV Primary medical care and support services • Documentation that agency billing and collection policies and procedures are in place that do not: o Deny services for non-payment o Deny payment for	• Include language in RFPs and contracts regarding access to care regardless of ability to pay and/or current or past health condition, and requirements regarding client eligibility criteria and use of fees and sliding fee scales • Review agency's billing,	N/A	RW Part B 2617 (b)(7)(B

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health conditions of the individuals to be served	inability to produce income documentation o Require full payment prior to service o Include any other procedure that denies services for non-payment o Permit denial of services due to pre-existing conditions o Permit denial of services due to non-HIV-related conditions o Provide any other barrier to care due to a person's past or present health condition	collection, co-pay, and sliding fee policies and procedures to ensure that they do not result in denial of services • Review agency eligibility and clinical policies • Investigate any complaints against the agency for denial of services • Review files of refused clients and client complaints • Investigate any complaints of agency "dumping" or "cherry picking" of patients		
d. Provision of Part B-funded HIV primary medical care and support services in settings that are accessible to low-income individuals with HIV disease	Documentation that: • Part B-funded HIV primary medical care and support services are provided in a facility that is handicapped accessible and accessible by public transportation where possible • Providers have in place policies and procedures that provide transportation if	• Specify in RFPs and contracts expectations that services be provided in settings that are accessible to low-income individuals with HIV disease • Inspect service provider facilities for ADA compliance, and location of facility with regard to	N/A	RW Part B 2617 (b)(7)(B)

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	facility is not accessible to public transportation • No provider policies dictate a dress code or conduct that may act as a barrier for low-income individuals	access to public transportation • Review policies and procedures for providing transportation assistance if facility is not accessible by public transportation		
e. Provision of a program of outreach efforts to inform low-income individuals with HIV disease of the availability of services and how to access them	• Use of informational materials about agency services and eligibility requirements including: o Brochures o Newsletters o Posters o Community Bulletins o Any other types of promotional materials • Documentation that any funded awareness activities target specific groups of low-income individuals with HIV disease to inform them of such services	Review documents indicating activities for promotion and awareness of the availability of HIV services	Maintain file documenting agency activities for the promotion of HIV services to low- income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements	RW Part B 2617 (b)(7)(b)
2. **Expenditure and Use of Funds** a. Compliance with statutory requirements regarding the timeframe for obligation and	Documentation that grantee has complied with statutory requirements regarding the timeframe for obligation and expenditure of funds, and with any cancellation of unobligated funds	• Establish systems to ensure that formula funds are spent first and to maximize timely expenditure of funds by providers to meet identified service needs • Ensure that providers	N/A	RW Part B 2618 (c-d) RW Part B 2622 (a-d)

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expenditure of funds, and with any cancellation of unobligated funds		understand the importance of timely expenditures and reporting and their responsibility for informing the grantee of expected under-expenditures • Ensure an efficient and timely reallocations process • Provide timely and accurate carryover requests • Comply with unobligated balance requirements		
b. Expenditure of funds for core medical services, support services approved by the Secretary of HHS, and administrative expenses only	Documentation of the grantee's expenditure of funds for core medical services, support services approved by the Secretary of HHS, and administrative expenses only	• Establish and maintain systems and procedures that ensure that funds are used only for permitted activities • Ensure that subgrantees understand and are required to use funds only for allowable service categories • Ensure that activities carried out within each service category meet HRSA definitions and are categorized and reported appropriately	N/A	RW Part B 2612

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c. Expenditure of not less than 75% of service dollars for core medical services, and expenditure of not more than 25% of service dollars for support services that contribute to positive clinical outcomes for individuals with HIV/AIDS, unless a waiver from this provision is obtained	Review of budgeted allocations and actual program expenses to verify that: • The grantee has met or exceeded the required 75% expenditure on HRSA-defined core medical services • Aggregated support service expenses do not exceed 25% of service funds • Support services are being used to help achieve positive medical outcomes for clients • These requirements are met, unless a waiver has been obtained	• Work with the consortia and advisory bodies to ensure that final allocations meet the 75%-25% requirement • Monitor program allocations, subgrantee agreements, actual expenditures, and reallocations throughout the year to ensure at least 75% percent of program funds are expended for HRSA- defined core medical services and no more than 25% percent of program funds are expended for HHS-approved support services • Require subgrantee monitoring and financial reporting that documents expenditures by program service category • Maintain budgets and funding allocations, subgrantee award information, and expenditure data with	N/A	RW Part B 2612 (a-d) RW Part B 2618 (c-d)

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		sufficient detail to allow for the tracking of core medical services and support services expenses • Document and assess the use of support service funds to demonstrate that they are contributing to positive medical outcomes for clients • If a waiver is desired, certify and provide evidence to HRSA/HAB that all core medical services funded under Part B program are available to all eligible individuals in the area through other funding sources		
d. Use of grant funds each fiscal year for each of the populations of women, infants, children and youth, not less than the percentage constituted by the ratio of the population in	Documentation of : • What percent of each of the specified populations constitutes the total AIDS population • The amount and percent of Part B program funds that are being used to serve each of these populations	• Prepare and submit the annual WICY Report • Submission of a WICY Waiver when needed	N/A	RW Part B 2612 (e)

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such area with HIV/AIDS to the general population in such area with HIV/AIDS, unless a waiver from this provision is obtained	• Whether the proportion of Ryan White Part B funds being used for each of the specified populations meets legislative requirements • Funds from other sources (such as Ryan White Part D) that are being used to meet the needs of these populations • A waiver request, with justification, if other funds are believed to be meeting the needs of any of these populations			
e. Compliance with legislative requirements regarding the Medicaid status of providers: funded providers of Medicaid-reimbursable services must be participating in Medicaid and certified to receive Medicaid payments or able to document efforts under way to obtain such certification for free clinics.	Documentation that funded providers providing Medicaid-reimbursable services either: • Are participating in Medicaid, certified to receive Medicaid payments, and using Medicaid funds whenever possible to cover services to people living with HIV disease • Are actively working to obtain such certification	Specify in RFPs and contracts that providers receiving Part B funding to provide Medicaid-reimbursable services are required to seek certification to receive Medicaid payments or to describe current efforts to obtain certification • Maintain documentation of each provider's Medicaid certification status	N/A	RW Part B 2652 (b)

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f. Maintenance of Effort (MOE), which includes the following: • Funds to be used to supplement, not supplant, local funds made available in the year for which the grant is awarded to provide HIV-related services to individuals with HIV disease • Political subdivisions within the State to maintain at least their prior fiscal year's level of expenditures for HIV-related services for individuals with HIV disease • State will not use funds received under Part B in maintaining the level of expenditures for HIV-related services as required in the above paragraph • Documentation of this maintenance of effort to be retained	Documentation of the grantee's Maintenance of Effort, including submission of non-Ryan White amounts allocated and assurances that: • Part B funds will be used to supplement, not supplant, local funds made available in the year for which the grant is awarded • Political subdivisions within the EMA/TGA will maintain at least their prior fiscal year's level of expenditures for HIV-related services • The State will not use funds received under Part B in maintaining the level of expenditures	Collect and submit the following MOE information to HRSA/HAB annually: • A list of core medical and support services, budget elements that will be used to document MOE in subsequent grant applications • A description of the tracking system that will be used to document these elements • Budget for State contributors • Tracking/accounting documentation of actual contributions	N/A	RW Part B 2617 (E)
g. Procedures in place to ensure that services	• Documentation that program services are being	• Review and monitor the licensing and certification	N/A	DSS Policy Guidance No. 4 Clarification of

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
are provided by appropriate entities: • Program services to be provided by public or nonprofit entities, or by private for-profit entities if they are the only available provider of quality HIV care in the area • Providers and personnel providing services expected to meet appropriate State and local licensure and certification requirements	provided by public or nonprofit entities unless private for-profit entities are the only available provider of quality HIV care in the area • Review of providers to ensure that the entities and the individuals providing services have appropriate licensure and certification, as required by the State and locality in which the provider is operating	of provider entities and staff to ensure they are valid and appropriate • Provide documentation of situations in which private for-profit entities are the only available provider of quality HIV care in the area • Have for-profit justification available for HRSA/HAB review as needed		Legislative Language Regarding Contracting with For Profit Entities 6/1/2000
h. Funded services to be integrated with other such services and coordinated with other available programs (including Medicaid), so that the continuity of care and prevention services of individuals with HIV is enhanced	Documentation that funded Part B providers are expected to work collaboratively with each other, other available programs, and prevention providers to enhance continuity of care, as specified in RFPs, contracts, scopes of work, and standards of care	• Specify in RFPs, contracts, and scopes of work expectations for service integration and coordination with other available programs • Work with the Planning Council and providers to improve linkages and strengthen the continuum of care • Encourage linkages between Part B providers and prevention providers • Describe in the annual grant application the	N/A	RW Part E 2681 (c)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		continuum of care and ways the entities are integrated and coordinated		
3. **Limitations on Use of Funds** a. Expenditure of no more than 10% of the grant on planning and evaluation and no more than 10% on administrative costs, but not more than 15% on these costs combined, with funds expended in accordance with the legislative definition of administrative activities, and allocation of funds to entities and subcontractors such that their aggregate expenditure of funds for administrative purposes does not exceed 10% of those funds	Documentation that : • Grantee expenditures for administrative costs including planning and evaluation do not exceed 15% of grant funds when combined • Aggregate subgrantee expenditures for administrative purposes do not exceed 10% of service dollars • Both grantee and subgrantee administrative expenditures meet the legislative definition of administrative activities	• Clearly define administrative cost caps and allowable activities in the RFP and contracts • Monitor subgrantee expenditures to ensure that: o They meet the legislative definition of administrative activities o In the aggregate they do not exceed 10% of service dollars • Identify and describe all expenses within grantee budget that are categorized as administrative costs, and ensure that such expenses do not exceed 10% of the Part B grant	N/A	RW Part B 2612 (a-d) RW Part B 2618 (b-d) HAB Policy Notices 97-01, 97-02, and 10-02 Dr. Parham-Hopson Letter 8/14/09, 4/8/10
b. Implementation of a Clinical Quality	Documentation that: • The grantee has	• Develop and implement a CQM plan	N/A	RW Part B 2618 (b)(E)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Management (CQM) program that meets HRSA requirements, with funding that does not exceed the lesser of 5% of total grant funds or $3 million	implemented a CQM program that that meets HRSA requirements • CQM funding does not exceed the lesser of 5% of program funds or $3 million	• Develop a CQM budget and separately track CQM costs • Provide a budget and a financial report to HRSA that separately identify all CQM costs		
c. No use of Part B funds for construction or to make cash payments to recipients of services	Documentation that no Part B funds are used for construction or to make cash payments to recipients of services	• Specify in RFPs, contracts, and scopes of work the requirement that no Part B funds be used for construction and that no funds be used to make cash payments to recipients of services ***[See Section F.5, Direct Cash Payment]*** • Document grantee costs and ensure that no funds are used for construction; if the grantee is also a service provider, ensure that no Part B funds are used for cash payments	N/A	RW Part B 2618 (b)
d. No use of Part B funds to pay for any item or service that can reasonably be expected to be paid under any State compensation program, insurance	Documentation and certification that no Part B funds have been used to pay for any item or service that could reasonably be expected to be paid for under any State compensation program, insurance policy, or Federal or	• Maintain documentation that all costs that can be paid under any State compensation program, insurance policy, or federal or State health benefits program (except for programs related to	N/A	RW Part B 2617 (b)(7)(F)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
policy, or any Federal or State health benefits program (except for programs related to Indian Health Service) or by an entity that provides health services on a prepaid basis	State health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis	the Indian Health Service) or by an entity that provides health services on a prepaid basis, have been paid under these programs and not through use of Part B funds • Provide certification that Part B funds have not been used in any of the specified situations		
e. No use of Part B funds for AIDS programs, or for development of materials, designed to promote or encourage, directly or indirectly, intravenous drug use or sexual activity, whether homosexual or heterosexual	***[See Section G.I, Drug Use and Sexual Activity]***	***[See Section G.I, Drug Use and Sexual Activity]***	N/A	RW Part E 2684
5. **Miscellaneous** a. Compliance with the statutory requirements regarding the imposition of charges for services, including: • No charges to an individual with income below 100% of the Federal Poverty Level	• Documentation of provider compliance with the statutory requirements regarding the imposition of charges for services: o No charges imposed on individuals with incomes below 100% of FPL o Charges imposed and caps observed for	• Specify in RFPs, contracts, and scopes of work the statutory requirements regarding the imposition of charges for services based on the service recipient's FPL • Require providers to provide documentation of their policies and systems	N/A	RW Part B 2617 (c)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
(FPL) • Charges to be imposed on individuals with incomes above 100% of the FPL • Annual calendar year cap on charges to be 5% of gross income for individuals with incomes of 100-200% of FPL, 7% if incomes of 200-300% of FPL, and 10% if incomes above 300% of FPL	individuals with incomes above 100% of the FPL • Review of provider systems for client charges to ensure appropriate sliding fee scales and caps, and recordkeeping to ensure that caps are not exceeded	related to charges for services and to document and report total charges imposed		
b. Submission every two years to the lead agency under Part B of audits consistent with Office of Management and Budget (OMB) Circular A-133 regarding funds expended under Part B	Documentation that all grantees within the State are submitting audits consistent with OMB Circular A-133 to the Part B lead agency every two years	Submit audits to Part B program every two years		RW Part B 2617 (b)(4)(E)
c. Permission for and cooperation with any Federal investigation undertaken regarding programs conducted under the Ryan White Part B Program	Documentation and certification that the State will cooperate with any Federal investigation regarding the Part B Grant	Specify in RFPs, contracts, and scopes of work the requirement that the State and its subcontractors will cooperate with any Federal investigation regarding the Part B Grant		RW Part B 2617 (b)(7)(D)
Section I: **Minority AIDS**				

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Initiative				
a. **Reporting** Submission of an Annual Plan 60 days after the budget start date that details: • The actual award amount • Anticipated number of unduplicated clients who will receive each service • Anticipated units of service • Planned client-level outcomes for each minority population served under the Minority AIDS Initiative (MAI)	Documentation that the grantee has submitted an MAI Annual Plan 60 days after the budget start date that contains required elements and meets HRSA/HAB reporting requirements	• Prepare and submit an MAI Annual Plan with specified content that meets HRSA/HAB reporting requirements • Ensure that provider contracts contain clear reporting requirements that include funds spent, units of service provided, and client-level outcomes within each minority population served under the initiative	• Establish and maintain a system that tracks and reports the following for MAI services: o Dollars expended o Number of clients served o Units of service overall and by race and ethnicity, women, infants, children, youth o Client-level outcomes	Part B Minority AIDS Initiative (MAI) Reporting Instructions
b. Submission of an Annual Report following completion of the MAI fiscal year	Documentation that the grantee has submitted an Annual Report on MAI services that includes: • Expenditures • Number and demographics of clients served • Outcomes achieved	• Prepare and submit a year-end report documenting expenditures, number and demographics of clients served, and the outcomes achieved • Ensure that provider contracts include clear reporting requirements	• Maintain a system to track and report MAI expenditures, the number and demographics of clients served, and the outcomes achieved • Provide timely data to the grantee for use in preparing the Annual Report	Part B Minority AIDS Initiative (MAI) Reporting Instructions
Section J: **Data Reporting Requirements**				
1. Submission of the **Ryan**	Documentation that the EMA	• Review the State's	N/A	Ryan White

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
White HIV/AIDS Program Services Report (RSR), which includes three components: the Grantee Report, the Service Provider Report, and the Client Report a. Submission of the online Grantee Report	or TGA has submitted the annual online Grantee Report and that it includes a complete list of service provider contracts and the services funded under each contract	organization's information for accuracy • Review and if necessary correct the pre-filled list of funded contractors and the list of the contracted services for each provider • Submit the grantee report electronically by the deadline • Include contract language requiring providers and subgrantees to meet the reporting requirements		HIV/AIDS Program Services Report Instruction Manual
b. Submission of the online service providers report	Documentation that all service providers have submitted their sections of the online service providers report	N/A	• Report all the Ryan White Services the provider offers to clients during the funding year • Submit both interim and final reports by the specified deadlines	Ryan White HIV/AIDS Program Services Report Instruction Manual
c. Submission of the online client report	Documentation that all service providers have submitted their sections of the online client report	N/A	• Maintain client-level data on each client served, including in each client record demographic status, HIV clinical information, HIV-care medical and support services received, and the client's Unique Client	Ryan White HIV/AIDS Program Services Report Instruction Manual

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
			Identifier • Submit this report online as an electronic file upload using the standard format • Submit both interim and final reports by the specified deadlines	
Section K: Consortia				
1. If established by the State at its discretion, **HIV care consortia** to be associations of one or more public health care and support service providers, and community-based organizations operating within geographic areas determined by the State to be most affected by HIV/AIDS ***Note**:* Private for-profit providers or organizations may be designated consortia if such entities are the only available providers of quality HIV care in an area	• Documentation of the geographic area within the state to be served by each consortium • A list of providers that operate within each consortium area and are a part of the consortium and documentation of their government or nonprofit status • In cases where a private for-profit organization is designated a consortium service provider, assurance that the for-profit entity is the only quality provider of care within the consortium area	• When making decisions on the creation and continued use of consortia, review information about proposed consortium providers and the services they provide. Require consortia to include in their applications: o information on the geographic region to be served and how they are affected by HIV/ADS o A listing of the HIV/AIDS service providers operating within the region and their government or nonprofit status • Obtain assurances from	• Maintain on file a list of the providers in its region • Document the geographic area served and how it is affected by HIV/AIDS and the providers that operate within that consortium area • Provide proof of non-profit status of funded providers in its consortium region • Provide appropriate assurances to the State in cases where a private for-profit organization is the only quality provider of care within the consortium area	RW Part B 2613 RW Part B 2613(a)(1) RW Part B 2613 (f)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		consortia when needed regarding the use and inclusion of for- profit entities as service providers • Monitor the list of provider agencies for each consortium to ensure that providers meet the requirements for consortium designation and participation		
2. **Consortium activities** to include planning, periodic program evaluation, and service delivery, through the direct provision of services or through agreements with other entities for the provision of outpatient health and supportive services as permitted under Ryan White legislation ***Note:*** All services provided or contracted through consortia are considered support services and must be counted as part of the maximum 25% of service	Documentation through program records and client files that: • All services provided with Part B funds are allowable under Ryan White legislation and HRSA policies • Services provided meet Ryan White service category definitions All services provided or contracted through a consortium are counted as support services	• Develop RFPs and contracts, consortium guidelines, and agreements that: o Clearly define allowable consortium activities o Specify required documentation to be included in client charts and consortium administrative files • Review client files and service documentation to ensure compliance with contractual and Ryan White programmatic requirements • Review assurances and agreements for the	• Maintain, and share with the grantee upon request, program and financial records that document: o Types of services provided o Use of funds only for allowable services o Assurances and agreements between consortium and providers • Maintain client charts that include the required elements as detailed by the grantee	RW Part B 2613

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
dollars that may be expended for such services		provision of services between the consortium and its provider network • Provide fiscal documentation that all services provided or contracted through a consortium are counted as support services in the allocation of service dollars		
3. Consortia to submit to the State signed **assurances** in order to receive funding from the State under Part B Program Assurances to affirm the following: • Within the geographic area in which the consortium operates, populations and subpopulations of individuals and families with HIV/AIDS have been identified, particularly those experiencing disparities in access and services and/or residing in historically	Signed assurances from each consortium that affirm: • Identification of populations and subpopulations of individuals and families with HIV/AIDS identified, particularly those experiencing disparities in access and services and residing in historically underserved communities • Consortium regional/geographic service plan that is consistent with the comprehensive plan and addresses the special care and service needs of the specified populations and subpopulations • The consortium's role as the single coordinating	• Provide guidance to consortia through RFPs, contracts, and written agreements on the need to submit the required assurances to the State in order to receive Part B funding • Obtain from consortia the appropriate signed assurances as part of the annual funding cycle	Sign assurances and submit to the State as required in order to receive Part B funds	RW Part B 2613 (b)(1)(A-C) RW Part B 2613 (b)(2)(A-B)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
underserved communities • The regional/geographic service plan established by the consortium is consistent with the State's comprehensive plan and addresses the special care and service needs of these populations and subpopulations of individuals and families with HIV/AIDS • The consortium will be the single coordinating entity that will integrate the delivery of services among the populations and subpopulations identified ***Note:*** An exception to be given if the State determines that subpopulations exist with unique service needs within a consortium area and their service needs cannot adequately or efficiently be addressed by a single consortium	entity that will integrate the delivery of services among the identified populations and subpopulations			
4. Consortia to be required	Review of each consortium	Develop an application	Submit to the State an	RW Part B 2613 (c)(1)(A)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
to submit **applications** to the State demonstrating that the consortium includes agencies and community-based organizations: • With a record of service to populations and subpopulations with HIV/AIDS requiring care within the community to be served, and • Representative of populations and subpopulations reflecting the local epidemic and located in areas in which such populations reside	application to ensure that it demonstrates the inclusion of agencies and community-based organizations: • With a documented record of services to populations and subpopulations with HIV/AIDS requiring care within the community to be served With staff, clients, and (for nonprofit providers) Board members representative of populations and subpopulations reflecting the local incidence of HIV and that are located in areas which such populations reside	process for consortia that meets specified requirements regarding the record of service and representativeness of consortium agencies and community-based organizations. Maintain on file a copy of each consortium's application	application that provides specific documentation that demonstrates the service record and representativeness of consortium agencies and community-based organizations	
5. Each consortium to conduct **needs assessment** of service needs within the geographic area to be served, and ensure participation by individuals living with HIV/AIDS in the needs assessment process	Documentation that each consortium has: • Conducted a needs assessment to determine the service needs of the populations and subpopulations of individuals with HIV/AIDS and their families within the geographic area to be served • Ensured the participation of	• Develop clear guidelines, agreements, RFPs, and contracts with consortia that specify the requirements for consortium needs assessments, including participation of individuals with HIV/AIDS • Review needs assessment documents to ensure that	• Conduct a needs assessment of the service needs of the populations and subpopulations of individuals with HIV/AIDS and their families within the geographic area to be served, meeting the requirements as specified by the State,	RW Part B 2613 (c)(1)(B)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	individuals with HIV/AIDS in the needs assessment process	requirements are met	including participation of individuals living with HIV/AIDS areas in the needs assessment process • Provide a copy of the needs assessment to the State for review	
6. Each consortium to have a **service plan** for the geographic region served that is based upon evaluations of service need and designed to meet local needs Consortium to demonstrate adequate planning to • Meet the special needs of families with HIV/AIDS, including family-centered and youth-centered care, and to provide assurances regarding content of the service plan • Address disparities in access and services and historically underserved communities	• A service plan description for each consortium providing documentation and assurances that the service plan addresses service needs and: o Specifies that service needs will be addressed through the coordination and expansion of existing programs before new programs are created o Provides for geographic service areas in metropolitan areas that correspond, to the extent practicable, to boundaries of local health and support service delivery systems o Ensures that rural case management services link available community	• Develop clear guidelines, agreements, RFP's and contracts with consortia that outline the requirements for service plans and planning for families with HIV/AIDS • Require specified assurances related to o Coordination and expansion of existing programs o Use of common service boundaries in urban areas o Use of case management to link support services to specialized HIV medical care in rural areas • Participation of individuals living with HIV/AIDS in needs assessment and	• Develop regional/geographic service plans for the consortia region that include required components and focus areas, attention to planning for families with HIV/AIDS, and participation of individuals living with HIV/AIDS • Provide specified written assurances to the State	RW Part B 2613 (c)(1)(B-C) RW Part B 2613 (c)(1)(F)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
State to receive assurances from consortia that through the service plan: • Service needs will be addressed through the coordination and expansion of existing programs before new programs are created • In metropolitan areas, the consortium's geographic service area corresponds to the geographic boundaries of local health and support service delivery systems to the extent practicable • In rural areas, case management services will link available community support services to specialized HIV medical services • Individuals living with HIV/AIDS have participated in the needs assessment and service planning	support services to specialized HIV medical services o Ensures the participation of individuals living with HIV/AIDS in needs assessment and service planning • Documentation of adequate planning to: o Meet the special needs for of families with HIV/AIDS, including family- and youth-centered HIV care services o Address disparities in access and services and historically underserved communities	service planning		
7. **Consultation** by each consortium with representatives of required entities in the	Documentation in each consortium's service plan that the establishment of the service plan involved	• Provide guidance to consortia through RFPs, contracts, and written agreements that	Maintain, and provide to the grantee on request, documentation that shows the involvement of the	RW Part B 2613 (c)(2)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
establishment of the service plan for the consortium region At a minimum, consultation to include representatives of at least the following: • Public health or other entity that provides or supports HIV-related ambulatory and outpatient health care services within the geographic area to be served • At least one community-based organization organized solely to provide HIV/AIDS services • Funded Part D program representatives; if none located in the consortium region, then organizations with a history of serving women, infants, children youth and families living with HIV • Diverse entities of the categories included in the membership of a Part A HIV health services	consultation with representatives of at least the following: • Public health or other entity that provides or supports HIV-related ambulatory and outpatient health care services • At least one community-based organization whose sole purpose is to provide HIV/AIDS services • Funded Part D program representatives or, if none, organizations with a history of serving women, infants, children youth and families living with HIV • Diverse entities like those included as members of Part A HIV health services planning councils	representatives of specified entities and types of entities must be consulted in the establishment of the service plan for the consortium region. • Review documentation of consultation with required entities, such as meeting dates, minutes, agendas, and attendance lists	required representatives in the development of the service plan for the consortium region, such meeting dates, minutes, agendas, and attendance lists	

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
planning council				
8. Each consortium to conduct periodic **evaluation** of its success in responding to identified needs and the cost-effectiveness of mechanisms used to deliver comprehensive care Each consortium required to • Report to the State the results of its evaluation • Make available upon request the data and methodology information needed for the State to conduct an independent evaluation	• Documentation of guidance provided to consortia by the State regarding evaluation requirements • Documentation that each consortium is conducting periodic evaluation of both consortium success in responding to identified needs and cost- effectiveness of mechanisms used to deliver comprehensive care, such as timetables and methodology for evaluations of success in meeting needs and cost-effectiveness of service delivery mechanisms • Grantee review of completed evaluations of service success and cost- effectiveness of service interventions in accordance with the established timeframes • Documentation that consortia are providing the State copies of evaluation results and both data and methodology necessary for	• Provide clear guidance to consortia in RFPs, contract language, and service agreements regarding evaluation requirements, including: o Legislative requirements for evaluation o State timetables and other guidelines for evaluation, such as a multi-year evaluation plan and description of what evaluation activities will be conducted each year • Requirement to report results and make data and methodology information available to the State for use in conducting independent evaluation • Receive and review evaluation results and methods	• Develop plans and methods to evaluate service success and the cost-effectiveness of mechanisms used to deliver comprehensive care • Conduct evaluations in accordance with guidelines and timetables determined by the State • Make evaluation results and methodology information available to the State on request, for review and for use in conducting independent evaluation	RW Part B 2613 (c)(1)(D-E)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	the State to conduct independent evaluation			
Section L: **AIDS Drug Assistance Program (ADAP)** ***Note:*** Additional information on ADAP is provided above in *Section B:* Core Service, #3.				
1. State to provide **outreach (awareness)** to individuals with HIV/AIDS, and as appropriate the families of such individuals regarding the State ADAP Program to facilitate access to treatments for such individuals and to document progress in making therapeutics available	Documentation of: • State efforts and methods used to raise awareness of the ADAP program to individuals with HIV/AIDS and their families • Design of systems to facilitate access to treatments • Progress made in successfully reaching populations in need of assistance, as indicated by new ADAP enrollment of individuals with HIV/AIDS from populations or locations identified as hard to reach	• Specify in RFPs, contracts, and scopes of work the requirement to provide outreach (awareness) of the ADAP program to those who may need it, facilitate access to ADAP and ways to document progress in making medications available • Include in State ADAP scope of activity specific plans and mechanisms for outreach and facilitation of access to treatments • Periodically review efforts to increase awareness of the State ADAP Program • Document assessments	• Document and make available to the State for inspection and review efforts to provide outreach (awareness) of the ADAP program • Provide documentation of the success of outreach and access facilitation efforts, including evidence of increased enrollment in ADAP by target populations	RW Part B 2616 (c)(3-5)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		of access and enrollment in ADAP by target populations		
2. State to encourage, support, and enhance **adherence** to and compliance with treatment regimens including related medical monitoring. Activities to include: a. Enabling eligible individuals to gain access to drugs b. Supporting adherence to the drug regiment necessary to experience the full health benefits afforded by the medications c. Providing services to monitor the client's progress in taking HIV-related medications ***Note:*** Cap of 5% of ADAP funds for these activities unless the State documents to the Secretary of HHS that an extraordinary circumstance exists, which increases cap to 10% of	• Documentation of expenditures demonstrating that no more than 5% of the State's ADAP budget is used for services that improve access to medications, increase and support adherence to medication regimens, and monitor client progress in taking HIV-related medications • Documentation of activities undertaken to improve access to medications, increase and support adherence to medication regiments, and help clients monitor their progress in taking HIV-related medications • Where applicable, documentation of extraordinary factors justifying the request to expend greater than 5% of ADAP budget on adherence tools and techniques •	• Specify in RFPs, contracts, and scopes of work the requirement that drug rebates received on drugs purchased from funds provided pursuant to this section (2616/ADAP) are applied to activities supported under this subpart (Part B), with priority given to activities described under this section (2616/ADAP). • Develop a system to track and monitor the receipt of drug rebate funds to ensure they are used to support additional ADAP activities • Develop and implement a plan for the use of drug rebate funds to support additional ADAP activities	• Develop and implement a system to track the receipt of drug rebates • Use and document that drug rebate funds are being used to support additional Part B or ADAP activities, with priority given to ADAP activities, following State direction on how to apply such funds	RW Part B 2616 (g) HAB Policy Notice 07-02

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
ADAP funding Extraordinary circumstances may include such factors as: • Demonstrated exceptionally low compliance and adherence rates among targeted segments of the clients receiving ADAP medications (e.g. active substance users, persons with serious mental illnesses, etc.), or • Significant new numbers of clients entering ADAP who are new recipients of drug therapies (as a result of other outreach activities)				
3. Documentation and data sharing regarding Ryan White Part B ADAP expenditures used to cover costs of medication co-pays or otherwise contribute to **true out-of-pocket (TrOOP) expense** for clients enrolled in Medicare Part D in the coverage gap phase of	Grantee documentation of: • Development and implementation of the data systems necessary to track and account for Part B payments for TrOOP expenses • Participation with the CMS online Coordination of Benefits (COB) contractor • Signed data sharing agreement between State	• **<u>Develop and implement necessary data systems for tracking and reporting Part B payments</u>** • Participate in data sharing with the CMS COB contractor • Sign a data sharing agreement with CMS and submit electronic enrollment files with		Dr. Parham-Hopson Letter, ADAP/TrOOP 11/23/10 The Affordable Care Act, Public Law 111-148, Section 3314

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
the Part D program, so that such payments are flagged and counted by the Centers for Medicare and Medicaid Services (CMS) as coming from ADAP as a "TrOOP eligible payer"	ADAP and CMS • Amount of ADAP funds used to cover TrOOP expenses for clients on Medicare Part D •	specific information for the TrOOP facilitation contractor • **Develop procedures to ensure that the client enrollment file includes a unique identification number or RxBIN/Processor Control Number for Medicare Part D enrollees** • Monitor expenditures and reporting to ensure that: o Payments made are for covered Part D drugs • Costs are flagged as being from ADAP to ensure they are counted for TrOOP		
***Section M:* State Application**				
1. Submission of a **Part B application** to the Secretary at such time, in such form and containing all agreements, assurances, and	Review of application to ensure that it contains all required agreements, assurances, and information as stated in the Part B Program Guidance each year, including a detailed description	Submit an application that meets HRSA/HAB requirements as stated annually in the Part B Guidance, including a description of the HIV-related services provided in		RW Part B 2617 (a) RW Part B 2617 (b)(1) Funding Opportunity

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
information the Secretary of HHS determines necessary in order to award a grant to the State under this program, including HRSA/HAB requirements as stated annually in the Part B Funding Opportunity Announcement and a detailed description of the HIV-related services provided in the State to individuals and families with HIV/AIDS during the previous year	of the HIV-related services provided in the State to individuals and families with HIV/AIDS during the previous year	the State during the previous year		Announcement
2. Application to provide **needs assessment information** including data as specified in the Part B Program Guidance and: • The demographics and size of the population of persons living with HIV and AIDS in the State • Unmet need data including an estimate using the Unmet Need Framework • Disparities in access to	Review of application to ensure inclusion of required needs assessment information, including: • The demographics and size of the HIV/AIDS population • Unmet need data including an estimate using the Unmet Need Framework • Disparities in access and services among affected subpopulations and historically underserved communities • An estimate and	• Conduct needs assessment and analysis that meets HRSA/HAB application requirements as specified in the Part B Program Guidance and *Needs Assessment Guide* • Include in the application needs assessment information on: • The demographics and size of the population of persons living with HIV and AIDS in the State	N/A	RW Part B 2617 (b)(2-3) Funding Opportunity Announcement Ryan White Needs Assessment Guide

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
and services among affected subpopulations and historically underserved communities • An estimate and assessment of progress and needs in the Early Identification of Individuals with HIV/AIDS (EIIHA)	assessment of progress and needs in the Early Identification of Individuals with HIV/AIDS (EIIHA) • Other data as specified in the Part B Program Guidance	• Unmet need, including an estimate using the Unmet Need Framework, • Disparities in access to and services among affected subpopulations and historically underserved communities • An estimate of the number of people in the State who know they are HIV-positive but are not in care and an assessment of progress and needs in EIIHA		
3. Designation in the application of a **lead State agency** to carry out the duties and functions of the Part B program, as specified in the Ryan White legislation, HRSA/HAB policies, and the Program Guidance Lead agency to: • Administer Part B grant funds • Conduct needs assessments and prepare	Designation in the application of a lead State agency and description of its plans to carry out the following duties and functions of the Part B program: • Administer Part B grant funds • Conduct needs assessments and prepare the state plan • Prepare grant applications for submission to HRSA/HAB • Receive Part B program notices	Submit an application that designates a lead State agency that has the capacity and specific plans to carry out all specified duties and functions of the Part B Program		RW Part B 2617 (b) (4) Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
the state plan • Prepare grant applications for submission to HRSA/HAB • Receive Part B program notices • Collect and submit audits in accordance with OMB circular A-133 Carry out other duties appropriate to facilitate the coordination of programs	• Collect and submit audits in accordance with OMB circular A-133 Carry out other duties appropriate to facilitate the coordination of programs under Part B			
4. Submission of a **comprehensive plan** to HRSA/HAB that describes the organization and delivery of HIV health care and support services to be funded with assistance under Ryan White Part B and meets other requirements as stated in the HRSA/HAB comprehensive plan guidance Plan to include the following: • Priorities for the	Review of comprehensive plan to ensure that it describes the organization and delivery of HIV health care and support services to be funded with assistance under Ryan White Part B and includes all specified components as stated in the legislation and the guidance provided by HRSA/HAB regarding the contents and timing for submission of the comprehensive plan	Prepare and submit a comprehensive plan to HRSA/HAB that includes all information and components specified in the legislation and in the guidance provided by HRSA/HAB	N/A	RW Part B 2617 (b)(5)(A-G)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgantee Responsibility	Source Citation
• A strategy for identifying individuals who know their HIV status and are not in care, • A strategy for the coordination with HIV prevention programs, programs for the prevention and treatment of substance abuse, • A description of how the quality of health and support services will be maximized • Coordination with other related services for individuals with HIV/AIDS • A description of how the resources allocated and prioritized for core and support services under this program are consistent with the Statewide Coordinated Statement of Need				