LOUISIANA

DEPARTMENT OF HEALTH

HEALTH INSURANCE PROGRAM
FOR
PEOPLE LIVING WITH HIV

STD/HIV PROGRAM
OFFICE OF PUBLIC HEALTH

RFP # 305PUR-LDHRFP-2016-HIP-HIV-OPH
Proposal Due Date/Time: December 9, 2016
4:00 P.M. CT

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Glossary

ADAP: AIDS Drug Assistance Program (national)
AIDS: Acquired Immunodeficiency Syndrome
CAREWare: Free, scalable software for documenting and managing Ryan White services
CBO: Community based organization
COB: Coordination of Benefits
COBRA: Consolidated Omnibus Budget Reconciliation Act
Contractor: The successful proposer who is awarded a contract
CQI: Continuous Quality Improvement
CT: Central Time
Department or LDH: Louisiana Department of Health
Discussions: For the purposes of this RFP, a formal, structured means of conducting written or oral communications/presentations with responsible Proposers who submit proposals in response to this RFP.
Emergency: For the purposes of this RFP, an instance that places a client in a time-sensitive jeopardy of losing his or her health insurance coverage and/or benefits
EOB: Explanation of Benefits
FPL: Federal Poverty Level
FFM: Federally Facilitated Marketplace
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)
LA HAP: Louisiana Health Access Program
LDAP: Louisiana Drug Access Program
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
PPACA: Patient Protection and Affordable Care Act
Proposer: And individual or organization submitting a proposal in response to an RFP
Redacted Proposal: The removal of confidential and/or proprietary information from one copy of the proposal for public records purposes
RFP: Request for Proposals
Shall: Denotes a mandatory requirement
SHP: STD/HIV Program
Should, May, Can: Denotes a preference, but not a mandatory requirement
SOB: Summary of Benefits
State: The State of Louisiana
STD: Sexually Transmitted Disease
T/TA: Training/Technical Assistance
Transaction Fee: Cost to adjudicate a claim
Will: Denotes a mandatory requirement

GENERAL INFORMATION

A. Background

1. The mission of the Louisiana Department of Health (LDH) 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 Louisiana Department of Health 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. LDH is comprised of the Medical Vendor Administration (Medicaid), the Office for Citizens with Developmental Disabilities, the Office of Behavioral Health, the 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 LDH.

3. LDH, 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. SHP receives an annual award from the Ryan White HIV/AIDS Treatment Extension Act of 2009 to address the medical and supportive service needs of low income persons living with HIV. The Ryan White HIV/AIDS Program is the largest Federal program focused exclusively on providing HIV care and treatment services to people living with HIV. Working with cities, states and local community-based organizations, the Program provides a comprehensive system of care for people living with HIV who are uninsured or underinsured.

Within SHP, the Louisiana Health Access Program (LA HAP) is specifically structured and staffed to increase access to medical care and medications for low income persons living with HIV. LA HAP provides medications to uninsured persons through a contract with a Pharmacy Benefits Manager (PBM). Individuals with a comprehensive health insurance plan that offers pharmacy benefits may request assistance from LA HAP in paying for their monthly health insurance premiums, as well as any related cost shares from co-payments, co-insurances and deductible requirements for medications or medical visits. Although all client applications are reviewed for program eligibility at SHP by LA HAP staff, payments for premiums and co-payments for medical visits for all eligible clients are paid by staff at the Health Insurance Program (HIP).

B. Goals and Objectives

The goal of the Health Insurance Program (HIP) RFP is to improve the health outcomes of low income persons living with HIV in Louisiana. Of those individuals who have been able to obtain assistance from the Louisiana Health Access Program (LA HAP) in procuring and maintaining comprehensive health insurance coverage, a vast majority (84%) have also been able to achieve viral suppression. This outcome is in compliance with the goals and objectives established by the National HIV/AIDS Strategy (NHAS) for 2020. This goal can be achieved and maintained through several key objectives:

1. Coordinate with SHP/LA HAP staff to assure the monthly payment of insurance premiums for all eligible clients. The current client census is near 4,500 persons, but will likely decrease by approximately half during 2016 due to the availability of comprehensive health coverage through Medicaid Expansion for persons reporting an income of 138% FPL and below.

2. Achieve an error rate (for human and technological oversights, combined) of 2% or less for the late payment or non-payment of insurance premiums for eligible clients that results in the loss of insurance coverage.

3. Make payments to medical providers for cost shares (co-payments, coinsurance payments, deductible requirements, etc.) within 15 business days of receipt of the adjudicated bill from the client or the provider so the client can avoid late fees, penalties and any negative impact on their credit history.

C. Purpose of RFP

The purpose of this RFP is for LDH Office of Public Health STD/HIV Program to obtain competitive proposals from qualified proposers to act as a program administrator and fiduciary agent for the statewide Health Insurance Program (HIP) for persons living with HIV in accordance with the specifications and conditions set forth herein. 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 deductible requirements. 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. 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.

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.

D. RFP Addenda

State shall reserve the right to change the schedule of events or revise any part of the RFP by issuing an addendum to the RFP at any time. Addenda, if any, will be posted at https://wwwcfprd.doa.louisiana.gov/osp/lapac/pubMain.cfm.
May also be posted at:
http://new.LDH.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. ADMINISTRATIVE INFORMATION

A. RFP Coordinator

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

Capucinca Harris-Roberts
Louisiana Department of Health
Office of Public Health, STD/HIV Program
1450 Poydras Street, Suite 2136
New Orleans, LA 70112
Email: Capucinca.Harris-Roberts@la.gov
Office: 504 – 568 - 7474
Fax: 504 – 568 - 7044

2. All communications relating to this RFP must be directed to the LDH RFP Coordinator person named above. All communications between Proposers and other LDH staff members concerning this RFP shall be strictly prohibited. Failure to comply with these requirements shall result in proposal disqualification.

3. This RFP is available in pdf at the following web links:
https://wwwcfprd.doa.louisiana.gov/osp/lapac/pubMain.cfm
http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

B. Proposer Inquiries

1. LDH will consider written inquiries regarding the requirements of the RFP or Scope of Services to be provided 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 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 (DATE) specified in the Schedule of Events to the following web link:
https://wwwcfprd.doa.louisiana.gov/osp/lapac/pubMain.cfm
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.

C. Pre-Proposal Conference

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 provided during the conference, the only official answer or position of the Department in response to written questions will be stated in writing and signed by an authorized agent of the Department. 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: https://wwwcfprd.doa.louisiana.gov/osp/lapac/pubMain.cfm

   May also be posted at: www.dhh.louisiana.gov.

D. Schedule of Events

LDH reserves the right to revise this schedule. Revisions, if any, before the Proposal Submission Deadline will be formalized by the issuance of an addendum to the RFP. Revisions after the Proposal Submission Deadline, if any, will be by written notification to the eligible proposers.

Schedule of Events	
Public Notice of RFP	November 4, 2016
Non-Mandatory Pre-Proposal Conference	November 16, 2016 STD/HIV Program office 1450 Poydras Street Suite 2136 New Orleans, LA 70112
Deadline for Receipt of Written Questions	November 21, 2016
Response to Written Questions	November 28, 2016
Deadline for Receipt of Written Proposals	December 9, 2016 4:00pm CT
Contract Award Announced	January 16, 2017
Contract Begins	April 1, 2017

NOTE: The State of Louisiana reserves the right to revise this schedule. Revisions, if any, before the Proposal Submission Deadline will be formalized by the issuance of an addendum to the RFP.

III. 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 deductible requirements. 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 the 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 procured through the federally facilitated marketplace (FFM), Medicare, COBRA, and private insurance (including group and individual policies). 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

General Requirements
Contractor shall:

1. Maintain all relevant and required documents with the Louisiana Secretary of State in order to conduct business in the State of Louisiana.

2. Maintain a physical business location in the State of Louisiana.

Programmatic Requirements
Contractor shall:

1. Within thirty (30) business days of the contract start date, designate one staff member as the primary programmatic point of contact for SHP personnel, as well as a back-up staff person for time sensitive client concerns. Additional staff may be designated as the primary contacts for fiscal issues or customer service.

2. Within sixty (60) business days of the contract start date, conduct outreach to physicians, clinics, hospitals and other care providers throughout the state to advise on the services provided through the Health Insurance Program (HIP) and the process for submitting bills/claims for co-payments and deductible requirements for eligible clients.

3. Provide training and technical assistance (T/TA) throughout the state to increase the knowledge of HIP services. These T/TA efforts may be provided to community based organizations, medical providers, clinics or hospitals and Ryan White-funded agencies throughout the state. Depending on the scope of the requests, training/technical assistance may be provided via telephone/conference call, through webinars or other web-based technology, or during scheduled in-person provider trainings. A report of all T/TA requests and completed activities shall be included in the Contractor's quarterly report.

4. Develop within the first thirty (30) business days of the contract start date, and maintain current contact information on referring agencies, medical providers, and health insurance providers (including Medicare, COBRA, private insurance plans for group and individual policies, and health insurance plans on the federally facilitated marketplace) to include, but not be limited to primary contact names, email addresses, telephone numbers, and mailing list of physical addresses.

5. Within thirty (30) business days of the contract start date, assign a primary contact person to respond to customer service inquiries. This individual must have customer service experience, be trained on and be knowledgeable of the program's services, and have access to client-level information to respond to participants' inquiries regarding program enrollment, eligible benefits and coverage information.

6. Within thirty (30) business days of the contract start date, establish and maintain a toll-free number, which shall be staffed during regular business hours (Monday-Friday, 8:30 am-5:00 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.

7. At a minimum, maintain bi-monthly telephone participation in the SHP Care and Services Unit meetings to provide and learn of statewide and program specific updates and information. Schedule a monthly in-person meeting with the SHP Health Insurance Program (HIP) Coordinator to review and discuss program objectives, staff concerns and general contract performance.

8. Participate in and/or present reports at relevant SHP meetings, including but not limited to, relevant CQI Steering Committee and sub-committee meetings; statewide conference calls, webinars or trainings; quarterly monitoring meetings; SHP Care and Services Unit meetings; other relevant HIV planning meetings; and the annual Monitoring Site Visit.

9. Within thirty (30) business days of the contract start date 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:
   - forms to request payment to medical providers
   - 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.

11. Within 90 days of the contract start date, work collaboratively with SHP/LA HAP staff to develop and implement a statewide tax reconciliation process for clients who qualify for an Advance Premium Tax Credit (APTC) through the federally facilitated marketplace (FFM).

Operations Requirements
Contractor shall:

1. Process all eligible premiums and cost shares (including co-payments, coinsurance, and/or deductible payments) for enrolled clients on a monthly or quarterly basis or as otherwise stipulated by a health insurance company. The Health Insurance Program (HIP) currently provides premium and medical cost share payment services to an average of 4,500 clients each year. However, with the implementation of expanded Medicaid services to persons at or below 138% of the FPL, that number is expected to decrease by approximately 50%.

2. Within 15 business days of receipt of bill/invoice, forward payments as it relates to clients' premiums and cost shares (co-payments, co-insurance and/or deductible costs) to medical care providers.

3. Within two business days, 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.

4. Within 15 business days of first contact, work with provider agencies to resolve billing issues. All billing issues will be paid within 10 business days after the issue has been resolved.

5. When feasible and/or cost effective, electronic payments should be prioritized over the availability of paper checks.

6. Forward all billing issues that are outstanding beyond a thirty (30) business day period to the OPH/SHP HIP Coordinator for assistance.

Staffing Requirements/Qualifications
Contractor shall:

1. Maintain staffing for all positions essential to this contract. This includes, but is not limited to, the HIP Director, the primary Customer Service Representative, and a staff person in Accounts Payable to authorize checks or electronic drafts.

2. Offer employment to individuals in leadership positions that have familiarity with accessing and utilizing web-based data systems, and who have at least an intermediate knowledge of Microsoft Word and Excel. The employee's ability to stratify, manipulate and analyze data would be desirable.

Record Keeping/Data Management Requirements
Contractor shall:

1. Within thirty (30) business days of the contract start date, train all essential HIP staff on the operation and utilization of the Ramsell and CAREWare databases. From that time forward, staff will 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.

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

3. Comply with all SHP and HRSA reporting requests and requirements within the timeline specified in the request. If the requested timeline is not feasible, SHP staff should be notified immediately and an alternate date, mutually agreeable to both parties, should be established.

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

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 thirty (30) business days of completion. If any deficiencies are found as a result of the audit, the contractor shall be required to rectify such issues within thirty (30) business days. If contractor does not rectify the audit issues within the thirty (30) business 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 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. Within sixty (60) business days of the contract start date, establish and submit to SHP for approval a quality assurance and monitoring protocol that adheres to the Goals and Objectives established by the 2020 National HIV/AIDS Strategy and current HRSA regulations, requirements and expectations.

3. 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.

4. Provide for external review of a minimum of 10% of all active client files on an annual basis to the HIP Coordinator and/or the Services Quality Manager/Program Evaluator.

5. Have a policy or protocol that outlines clients' "Rights and Responsibilities" and maintain a client Grievance Policy with a resolution timeline of no greater than thirty (30) business days. These two documents should be included as attachments.

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. The Department may also delay the assessment of liquidated damages if it is in the best interest of the Department to do so. The Department may give notice to the Contractor of a failure to meet performance standards but delay the assessment of liquidated damages in order to give the Contractor an opportunity to remedy the deficiency; if the Contractor subsequently fails to remedy the deficiency to the satisfaction of the Department, LDH may reassert the assessment of liquidated damages, even following contract termination.
   - **a.** Late submission of a SHP required report - $50 per working day, per report.
   - **b.** Late submission of a HRSA required 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 - $50 per client file
   - **d.** Failure to respond to a client emergency in the required timeline - $50 per day, per client.
   - **e.** Failure to fill any vacant contractually required key staff positions within 90 days - $50 per working day from 91st day of vacancy until filled
   - **f.** Late submission of invoices beginning ten 10 business days after the stated due date - $50 per working day per invoice.

2. The decision to impose liquidated damages may 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;
   - **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 will be required to transmit all non-proprietary data which is relevant for analytical purposes to LDH on a regular schedule in XML format. Final determination of relevant data will be made by LDH based on collaboration between both parties. The schedule for transmission of the data will be established by LDH and dependent on the needs of the Department related to the data being transmitted. XML files for this purpose will be transmitted via SFTP to the Department. Any other data or method of transmission used for this purpose must be approved via written agreement by both parties.

- The contractor is responsible for procuring and maintaining hardware and software resources which are sufficient to successfully perform the services detailed in this RFP. The databases required for the successful operation of a statewide Health Insurance Program (HIP) will be provided to the successful proposer by the STD/HIV Program, and training will be available for both new and current staff on the appropriate and accurate use of these resources.
- The contractor should adhere to state and federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of this RFP.
- Unless explicitly stated to the contrary, the contractor is responsible for all expenses required to obtain access to LDH systems or resources which are relevant to successful completion of the requirements of

this RFP. The contractor is also responsible for expenses required for LDH to obtain access to the Contractor's systems or resources which are relevant to the successful completion of the requirements of this RFP. Such expenses are inclusive of hardware, software, network infrastructure and any licensing costs.

- Any confidential information must be encrypted to FIPS 140-2 standards when at rest or in transit.
- Contractor owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, HIPAA part 164)
- Any contractor use of flash drives or external hard drives for storage of LDH data must first receive written approval from the Department and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.
- All contractor utilized computers and devices must:
  - Be protected by industry standard virus protection software which is automatically updated on a regular schedule.
  - Have installed all security patches which are relevant to the applicable operating system and any other system software.
  - Have encryption protection enabled at the Operating System level.

F. Subcontracting

1. The State shall have a single prime contractor as the result of any contract negotiation, and that prime contractor shall be responsible for all deliverables specified in the RFP and proposal. This general requirement notwithstanding, proposers may enter into subcontractor arrangements, however, should acknowledge in their proposals total responsibility for the entire contract.

2. If the proposer intends to subcontract for portions of the work, the proposer shall identify any subcontractor relationships and include specific designations of the tasks to be performed by the subcontractor. Information required of the proposer under the terms of this RFP shall also be required for each subcontractor. The prime contractor shall be the single point of contact for all subcontract work.

3. Unless provided for in the contract with the State, the prime contractor shall not contract with any other party for any of the services herein contracted without the express prior written approval of the Department.

G. Compliance With Civil Rights Laws

1. The contractor agrees to abide by the requirements of the following as applicable: Title VI and Title VII of the Civil Rights Act of 1964, as amended by the Equal Opportunity Act of 1972, Federal Executive Order 11246, the Federal Rehabilitation Act of 1973, as amended, the Vietnam Era Veteran's Readjustment Assistance Act of 1974, Title IX of the Education Amendments of 1972, the Age Act of 1975, and contractor agrees to abide by the requirements of the Americans with Disabilities Act of 1990.

2. Contractor agrees not to discriminate in its employment practices, and will render services under this contract without regard to race, color, religion, sex, sexual orientation, gender identity, age, national origin, veteran status, political affiliation, disability, or any other non-merit factor. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this contract.

H. 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 Workers' Compensation coverage only.

1. Contractor's Insurance

The Contractor shall not commence work under this contract until it has obtained all insurance required herein, including but not limited to Automobile Liability Insurance, Workers' Compensation Insurance

and General Liability Insurance. 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' written 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.

I. Resources Available to Contractor

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

J. Contract Monitor

All work performed by the contract will be monitored by the HIP Coordinator (as the primary contract monitor) or designee:

Currently Vacant
HIP Coordinator Supervisor: Kira Radtke Friedrich
Services Manager
Louisiana Department of Health
Office of Public Health STD/HIV Program
1450 Poydras Street, Suite 2136
New Orleans, LA 70112

K. Term of Contract

1. The contract shall commence on or near the date approximated in the Schedule of Events. The initial term of this contract shall be three (3) years. With all proper approvals and concurrence with the successful contractor, LDH may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial contract term. Prior to the extension of the contract beyond the initial thirty –six (36) month term, approval by the Joint Legislative Committee on the Budget (JLCB) or other approval authorized by law shall be obtained. Such written evidence of JLCB approval shall be submitted, along with the contract amendment to the Office of State Procurement (OSP) to extend contract terms beyond the initial three (3) year term. The total contract term, including extensions, shall not exceed five (5) years. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract, as well as the annual programmatic guidance and fiscal award from the Health Resources and Services Administration (HRSA).

2. No contract/amendment shall be valid, nor shall the state be bound by the contract/amendment, until it has first been executed by the head of the using agency, or his designee, the contractor and has been approved in writing by the director of the Office of State Procurement.

L. Payment Terms

1. 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 shall be subject to approval of the STD/HIV Administrative Director as the approval authority or designee. Continuation of payment shall be dependent upon available funding.

2. Payments will be made to the Contractor after written acceptance by the Louisiana Department of Health of the payment task and approval of an invoice. LDH will make every reasonable effort to make payments within ***thirty*** (***30) calendar days*** of the approval of invoice and under a valid contract. Such payment amounts for work performed must be based on at least equivalent services rendered, and to the extent practical, will be keyed to clearly identifiable stages of progress as reflected in written reports submitted with the invoices. Contractor will not be paid more than the maximum amount of the contract.

IV. 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 LDH until an award is made.

C. Code of Ethics

1. The contractor acknowledges that Chapter 15 of Title 42 of the Louisiana Revised Statutes (R.S. 42:1101 et. seq., Code of Governmental Ethics) applies to the Contracting Party in the performance of services called for in this contract. The contractor agrees to immediately notify the state if potential violations of the Code of Governmental Ethics arise at any time during the term of this contract.
2. 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 does not constitute a commitment by LDH to award a contract(s). The Department shall reserves the right to take any of the following actions that it determines to be in its best interest:

1. Reject, in whole or part, all proposals submitted in response to this solicitation;

2. Cancel this RFP; or

3. Cancel or decline to enter into a contract with the successful proposer at any time after the award is made and before the contract receives final approval from the Division of Administration, Office of State Procurement.

E. Right to Prohibit Award

In accordance with the provisions of R.S. 39:2192, any public entity shall be authorized to reject a proposal 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 RFP awarded under the laws governing public contracts under the provisions of Chapter 10 of Title 38 of the Louisiana Revised Statutes of 1950, and all contracts under Title 39, Chapter 17 of the Louisiana Procurement Code including contracts for professional, personnel, consulting and social services.

F. Contract Award and Execution

1. The Secretary of LDH reserves the right to:
   a. Make an award without presentations by proposers or further discussion of proposals received.
   b. Enter into a contract without further discussion of the proposal submitted based on the initial offers received.
   c. Contract for all or a partial list of services offered in the proposal.

2. The RFP and proposal of the selected Proposer shall become part of any contract initiated by the State.

3. The selected Proposer shall be expected to enter into a contract that is substantially the same as the sample contract included in Attachment II. In no event shall a Proposer submit its own standard contract terms and conditions as a response to this RFP. The Proposer should submit with its proposal any exceptions or exact contract deviations that its firm wishes to negotiate. Negotiations may begin with the announcement of the selected Proposer.

4. If the contract negotiation period exceeds thirty (30) calendar days or if the selected Proposer fails to sign the final contract within fifteen (15) business days of delivery, the State may elect to cancel the award and award the contract to the next-highest-ranked Proposer.

G. Assignments

No contractor shall assign any interest in this contract by assignment, transfer, or novation, without prior written consent of the State. This provision shall not be construed to prohibit the contractor from assigning to a bank, trust company, or other financial institution any money due or to become due from approved contracts without such prior written consent. Notice of any such assignment or transfer shall be furnished promptly to the State.

H. Determination of Responsibility

Determination of the proposer's responsibility relating to this RFP shall be made according to the standards set forth in LAC 34:V.2536. The State must find that the selected proposer:

1. Has adequate financial resources for performance, or has the ability to obtain such resources as required during performance;
2. Has the necessary experience, organization, technical qualifications, skills, and facilities, or has the ability to obtain them;
3. Is able to comply with the proposed or required time of delivery or performance schedule; Has a satisfactory record of integrity, judgment, and performance; and
4. Is otherwise qualified and eligible to receive an award under applicable laws and regulations.
5. Proposers should ensure that their proposals contain sufficient information for the State to make its determination by presenting acceptable evidence of the above to perform the contracted services.

I. Proposal and Contract Preparation Costs

The proposer assumes sole responsibility for any and all costs and incidental expenses associated with the preparation and reproduction of any proposal submitted in response to this RFP. The proposer to which the contract is awarded assumes sole responsibility for any and all costs and incidental expenses that it may incur in connection with: (1) the preparation, drafting or negotiation of the final contract; or (2) any activities that the proposer may undertake in preparation for, or in anticipation or expectation of, the performance of its work under the contract before the contract receives final approval from the Division of Administration, Office of State Procurement. The proposer shall not include these costs or any portion thereof in the proposed contract cost. The proposer is fully responsible for all preparation costs associated therewith even if an award is made but subsequently terminated by the Department.

J. Blackout Period

The Blackout Period is a specified period of time during a competitive sealed procurement process in which any proposer, bidder, or its agent or representative, is prohibited from communicating with any state employee or contractor of the State involved in any step in the procurement process about the affected procurement. The Blackout Period applies not only to state employees, but also to any contractor of the State. "Involvement" in the procurement process includes but may not be limited to project management, design, development, implementation, procurement management, development of specifications, and evaluation of proposals for a particular procurement. All solicitations for competitive sealed procurements will identify a designated contact person, as per Section 1.7.2 of this RFP. All communications to and from potential proposers, bidders, vendors and/or their representatives during the Blackout Period must be in accordance with this solicitation's defined method of communication with the designated contact person. The Blackout Period will begin upon posting of the solicitation. The Blackout Period will end when the contract is awarded.

In those instances in which a prospective proposer is also an incumbent contractor, the State and the incumbent contractor may contact each other with respect to the existing contract only. Under no circumstances may the State and the incumbent contractor and/or its representative(s) discuss the blacked-out procurement.

Any bidder, proposer, or state contractor who violates the Blackout Period may be liable to the State in damages and/or subject to any other remedy allowed by law.

Any costs associated with cancellation or termination will be the responsibility of the proposer or bidder.

Notwithstanding the foregoing, the Blackout Period shall not apply to:

1. A protest to a solicitation submitted pursuant to La. R.S. 39:1671;

2. Duly noticed site visits and/or conferences for bidders or proposers;

3. Oral presentations during the evaluation process

4. Communications regarding a particular solicitation between any person and staff of the procuring agency provided the communication is limited strictly to matters of procedure. Procedural matters include deadlines for decisions or submission of proposals and the proper means of communicating regarding the procurement, but shall not include any substantive matter related to the particular procurement or requirements of the RFP

K. Errors and Omissions

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

L. 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.

M. Procurement Library/Resources Available To Proposer

Relevant material related to this RFP will be posted at the following web address: http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47

Charges for copying are twenty-five cents ($0.25) per page, payable at the time copies are made. Cash is not acceptable. Checks and/or money orders are to be made payable to the Louisiana Department of Health."

N. 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 one (1) electronic copy (CD or flash drive) of the complete unredacted proposal, along with five (5) additional hard copies of the proposal. Proposer shall also submit one (1) electronic copy (CD or flash drive) of the redacted proposal, if any, and may submit one (1) hard copy. No facsimile or emailed proposals will be accepted. The cost proposal and financial statements shall 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:
Capucinca Harris-Roberts
Louisiana Department of Health
Office of Public Health STD/HIV Program
1450 Poydras Street, Suite 2136
New Orleans, LA 70112

If delivered via US Mail:
Capucinca Harris-Roberts
Louisiana Department of Health
Office of Public Health STD/HIV Program

1450 Poydras Street, Suite 2136
New Orleans, LA 70112

O. Confidential Information, Trade Secrets, and Proprietary Information

1. All financial, statistical, personal, technical and other data and information relating to the State's operation which are designated confidential by the State and made available to the contractor in order to carry out this contract, or which become available to the contractor in carrying out this contract, shall be protected by the contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the State. The identification of all such confidential data and information as well as the State's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by the State in writing to the contractor. If the methods and procedures employed by the contractor for the protection of the contractor's data and information are deemed by the State to be adequate for the protection of the State's confidential information, such methods and procedures may be used, with the written consent of the State, to carry out the intent of this paragraph. The contractor shall not be required under the provisions of the paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the contractor's possession, is independently developed by the contractor outside the scope of the contract, or is rightfully obtained from third parties.

2. Under no circumstance shall the contractor discuss and/or release information to the media concerning this project without prior express written approval of the Louisiana Department of Health.

3. Only information which is in the nature of legitimate trade secrets or non-published financial data shall be deemed proprietary or confidential. Any material within a proposal identified as such must be clearly marked in the proposal and will be handled in accordance with the Louisiana Public Records Act, R.S. 44:1-44, and applicable rules and regulations. Any proposal marked as confidential or proprietary in its entirety shall be rejected without further consideration or recourse.

P. 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.

Q. Requested Proposal Outline:

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

R. Proposal Content

1. **Cover Letter**
   A cover letter should be submitted on the Proposer's official business letterhead explaining the intent of the Proposer.

2. **Table of Contents**
   The proposal should be organized in the order contained herein.

3. **Quality And Timeliness**

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. Work samples may be included as part of the proposal.

4. Assume Complete Responsibility

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.

5. Approach and Methodology

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 III. Proposals should include enough information to satisfy evaluators that the Proposer has the appropriate experience, knowledge and qualifications to perform the scope of services as described herein. Proposers should respond to all requested areas.

6. 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 the LDH Office of Public Health STD/HIV Program as related to the scope of this RFP for the provision of services through the Health Insurance Program (HIP). It should further cite its ability to satisfy provisions of the RFP.

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 shall also include the following information:

- **i.** Location of Administrative 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 LDH 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.

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 I).

7. 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 address the following:

a. Provide a written and/or visual explanation of the organizational structures of both operations and program administration, and how those structures will support service implementation. Individual components should include plans for hiring qualified staff, providing supervision, assuring continued staff training/professional development, documenting the work performed, monitoring progress, implementing quality control mechanisms, providing technical assistance, and communicating with SHP staff and community partners.

b. Demonstrate knowledge of services to be provided and describe effective strategies to maximize program productivity while maintaining a high degree of accuracy in financial and client level data.

c. Describe the proposer's experience and expertise in coordinating and communicating with health insurance providers in Louisiana (such as private insurance companies, including group and individual policies), health insurance plans that participate in the federally facilitated marketplace (FFM), Medicare, COBRA, etc.), or the proposer's ability and experience in developing such relationships.

d. Describe in detail the workflow process between medical care providers, health insurance providers, clients, community partners, SHP personnel and the proposer. The description should include timelines for accomplishments, as well as flowcharts or other visual presentations of the process.

e. Describe the ability to make premium payments and medical care copayment/coinsurance payments on behalf of eligible clients, and the process by which these payments will be made. Address any challenges of making payments upfront for the duration of a month while preparing an invoice to SHP at the end of each month. Include the expected timeline required to process payments as well as a plan for tracking and documenting confirmation of payments.

f. Describe the mechanism by which communication with health insurance companies, medical care providers and/or clients will occur in order to resolve specific client issues, inform them of significant events and/or advise of program changes.

g. Describe 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 will ensure that there is adequate personnel who are trained to provide coverage during transition times, such as when key personnel are on vacation or when an essential position becomes vacant.

h. Provide a detailed description of the payment 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.

i. Describe the process to monitor billing to assure non-duplication and the proper split between primary, secondary and (if applicable) tertiary payers.

j. Describe the process for obtaining credits and adjustments for any possible overpayments that have been made.

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

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

m. Describe current plans and activities to support quality assurance and continuous quality improvement; this includes (but is not limited to) reviewing the quality of services provided, surveying clients about their experience(s), the error rate of specific tasks, staff productivity, and collaboration with the STD/HIV Program of the Office of Public Health to be able to document client health outcomes. Describe current quality assurance activities and measures, including the ability and timeline required to produce utilization and expenditure reports. Include examples of previous survey tools and outcomes as attachments.

n. Demonstrate an ability to hire staff with the necessary experience and skill set that will enable them to effectively meet the needs of consumers served.

o. Client confidentiality is extremely important and the Contractor must be compliant with all confidentiality requirements imposed by Louisiana law, LDH rules and guidelines, HIPAA Privacy and Security Rules, the federal HITECH Act of 2009, and other applicable federal laws and regulations. Document procedures to protect the confidentiality of records in LDH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.

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

q. 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.

r. Articulate the ability to develop and implement an All Hazards Response plan in the event of an emergency event.

s. Identify all assumptions or constraints on tasks.

t. Discuss what flexibility exists within the work plan to address unanticipated problems which might develop during the contract period.

u. If the proposer intends to subcontract for portions of the work, the proposer should identify any subcontractor relationships and include specific designations of the tasks to be performed by the subcontractor. Information required of the proposer under the terms of this RFP shall also be required for each subcontractor. The primary Contractor shall be the single point of contact for all subcontract work.

8. Relevant Corporate Experience

a. The proposal should indicate the proposer's firm has a record of prior successful experience in the 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 twenty-four (24) months, implemented a similar type project. Proposers should give at least two written customer references for projects implemented in at least the last twenty-four 24 months. References shall 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.

9. Personnel Qualifications

a. The purpose of this section is to evaluate the relevant experience, resources, and qualifications of the proposed staff 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 staff, professional skill mix, and level of involvement of personnel.

b. Proposers shall 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.

c. 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 staff 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.

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

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

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

f. 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. The successful proposer may not exceed three (3) subcontractors.

10. 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.

11. Corporate Financial Condition

1. 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.

2. Proposal shall 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.

12. Cost and Pricing Analysis

a. Proposer shall specify costs for performance of tasks. 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 to the attached sample cost template form (See Attachment IV) for each year of the contract to demonstrate how cost was determined. Proposers must complete a cost proposal in the following format to be considered for award. Failure to complete will result in the disqualification of the proposal.

c. Administrative costs may include usual and recognized overhead activities, facility costs, and the costs of management oversight of activities proposed under this RFP. This may include 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. These costs should be added together and expressed as a percent of the direct costs (the direct costs are proposed costs for health insurance premium payments and co-pays and deductibles). In accordance with thelegislative 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 service's.

S. Waiver of Administrative Informalities

The Louisiana Department of Health reserves the right, at its sole discretion, to waive minor administrative informalities contained in any proposal.

T. Withdrawal of Proposal

A proposer may withdraw a proposal that has been submitted at any time up to the date and time the proposal is due. To accomplish this, a written request signed by the authorized representative of the proposer must be submitted to the RFP Coordinator.

V. EVALUATION AND SELECTION

A. 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 LDH Office of the Secretary, Division of Fiscal Management.

3. Scoring will be based on a possible total of **100** points 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 three years shall receive 25 points. Other proposers shall receive points for cost based upon the following formula:

CCS = (LPC/PC)* 25

CCS=Computed Cost Score (points) for proposer being evaluated
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 cost evaluator assigned by the issuing program (in this case, the STD/HIV Program of the Office of Public Health).

5. Hudson/Veteran Small Entrepreneurship Program

a. 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.

6. Evaluation Criteria and Assigned Weights

Proposals that pass the preliminary screening and mandatory requirements review will be evaluated based on information provided in the proposal. The evaluation will be conducted according to the following:

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

B. On Site Presentation/Demonstration

Not required for this RFP.

C. Evaluation Team

The evaluation of proposals will be accomplished by an evaluation team, to be designated by the Department, which will determine the proposal most advantageous to the Department, taking into consideration cost and the other evaluation factors set forth in the RFP.

D. Administrative and Mandatory Screening

All proposals will be reviewed to determine compliance with administrative and mandatory requirements as specified in the RFP. Proposals that are not in compliance will be excluded from further consideration.

E. Clarification of Proposals

The Department reserves the right to seek clarification of any proposal for the purpose of identifying and eliminating minor irregularities or informalities, including resolving inadequate proposal content, or contradictory statements in a proposer's proposal.

F. Announcement of Award

1. The Evaluation Team will compile the scores and make a recommendation to the head of the agency on the basis of the responsive and responsible proposer with the highest score.

2. The State will notify the successful Proposer and proceed to negotiate terms for final contract. Unsuccessful proposers will be notified in writing accordingly.

3. The proposals received ***(except for that information appropriately designated as confidential in accordance with R.S. 44:1 et seq.),*** selection memorandum along with list of criteria used along with the weight assigned each criteria; scores of each proposal considered along with overall scores of each proposal considered, and a narrative justifying selection shall be made available, upon request, to all interested parties after the "Notice of Intent to Award" letter has been issued.

4. Any Proposer aggrieved by the proposed award has the right to submit a protest in writing to the head of the agency issuing the proposal within ***14 calendar days*** after the award has been announced by the agency.

5. The award of a contract is subject to the approval of the Division of Administration, Office of State Procurement.

G. Best and Final Offers (BAFO)

1. The State reserves the right to conduct a BAFO with one or more proposers determined by the committee to be reasonably susceptible of being selected for award. If conducted, the proposers selected will receive written notification of their selection, with a list of specific items to be addressed in the BAFO along with instructions for submittal. The BAFO negotiation may be used to assist the state in clarifying the scope of work or to obtain the most cost effective pricing available from the proposers.

2. The written invitation to participate in BAFO will not obligate the state to a commitment to enter into a contract.

VI. SUCCESSFUL CONTRACTOR REQUIREMENTS

A. Confidentiality of Data

1. All financial, statistical, personal, technical and other data and information relating to the State's operation which are designated confidential by LDH and made available to the contractor in order to carry out this contract, or which become available to the contractor in carrying out this contract, shall be protected by the contractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to LDH. The identification of all such confidential data and information as well as LDH's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by LDH in writing to the contractor. If the methods and procedures employed by the contractor for the protection of the contractor's data and information are deemed by LDH to be adequate for the protection of LDH's confidential information, such methods and procedures may be used, with the written consent of LDH, to carry out the intent of this paragraph. The contractor shall not be required under the provisions of the paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the contractor's possession, is independently developed by the contractor outside the scope of the contract, or is rightfully obtained from third parties.

2. Under no circumstance shall the contractor discuss and/or release information to the media concerning this project without prior express written approval of the ***Louisiana Department of Health.***

B. Taxes

Contractor is responsible for payment of all applicable taxes from the funds to be received under this contract.

C. Fund Use

Contractor agrees not to use contract proceeds 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 Louisiana Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition on any election ballot or a proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority.

VII. CONTRACTUAL INFORMATION

A. Contract

The contract between LDH and the Contractor shall include the standard LDH contract form CF-1

(Attachment II) 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. In addition to the 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 first priority to provisions of the contract excluding the RFP and the proposal; second priority to the provisions of the RFP and its amendments and addenda; and third priority to the provisions of the proposal.

4. **Entire Agreement**
   This contract, together with the RFP and its amendments 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 to 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. **Corporation Requirements**
   If the contractor is a corporation, the following requirements must be met prior to execution of the contract:
   - **a.** If the contractor is a for-profit corporation whose stock is not publicly traded, the contractor shall ensure that a disclosure of ownership form has been properly filed with the Secretary of State of Louisiana.
   - **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 Department 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.

9. **Contract Controversies**
   Any claim or controversy arising out of the contract shall be resolved by the provisions of Louisiana Revised Statutes 39:1672.2-1672.4.

10. **Right To Audit**
    The State Legislative Auditor, agency, and/or federal auditors and internal auditors of the Division of Administration shall have the option to audit all accounts directly pertaining to the contract for a period of three (3) years from the date of the last payment made under this contract. Records shall be made available during normal working hours for this purpose.

11. **Contract Modification**
    No amendment or variation of the terms of this contract shall be valid unless made in writing, signed by the parties and approved as required by law. No oral understanding or agreement not incorporated in the contract is binding on any of the parties.

12. **Severability**
    If any term or condition of this Contract or the application thereof is held invalid, such invalidity shall not affect other terms, conditions, or applications which can be given effect without the invalid term, condition, or application; to this end the terms and conditions of this Contract are declared severable.

13. **Applicable Law**
    This contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana. Venue of any action brought with regard to this contract shall be in the Nineteenth Judicial District Court, Parish of East Baton Rouge, State of Louisiana.

B. Mutual Obligations and Responsibilities

The state requires that the mutual obligations and responsibilities of LDH 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 (Attachment II).

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) business 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, the Department shall release all retained amounts to the contractor.

D. Indemnification and Limitation of Liability

1. Neither party shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. The parties shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under Contract.

2. Contractor shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and hold harmless the State and its Authorized Users from suits, actions, damages and costs of every name and description relating to personal injury and damage to real or personal tangible property caused by Contractor, its agents, employees, partners or subcontractors, without limitation; provided, however, that the Contractor shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the State. If applicable, Contractor will indemnify, defend and hold the State and its Authorized Users harmless, without limitation, from and against any and all damages, expenses (including reasonable attorneys' fees), claims, judgments, liabilities and costs which may be finally assessed against the State in any action for infringement of a United States Letter Patent with respect to the Products furnished, or of any copyright, trademark, trade secret or intellectual property right, provided that the State shall give the Contractor:

(i) prompt written notice of any action, claim or threat of infringement suit, or other suit, (ii) the opportunity to take over, settle or defend such action, claim or suit at Contractor's sole expense, and (iii) assistance in the defense of any such action at the expense of Contractor. Where a dispute or claim arises relative to a real or anticipated infringement, the State or its Authorized Users may require Contractor, at its sole expense, to submit such information and documentation, including formal patent attorney opinions, as the Commissioner of Administration shall require.

3. The Contractor shall not be obligated to indemnify that portion of a claim or dispute based upon: i) Authorized User's unauthorized modification or alteration of a Product, Material or Service; ii) Authorized User's use of the Product in combination with other products not furnished by Contractor; iii) Authorized User's use in other than the specified operating conditions and environment.

4. In addition to the foregoing, if the use of any item(s) or part(s) thereof shall be enjoined for any reason or if Contractor believes that it may be enjoined, Contractor shall have the right, at its own expense and sole discretion as the Authorized User's exclusive remedy to take action in the following order of precedence: (i) to procure for the State the right to continue using such item(s) or part (s) thereof, as applicable; (ii) to modify the component so that it becomes non-infringing equipment of at least equal quality and performance; or (iii) to replace said item(s) or part(s) thereof, as applicable, with non-infringing components of at least equal quality and performance, or (iv) if none of the foregoing is commercially reasonable, then provide monetary compensation to the State up to the dollar amount of the Contract.

5. For all other claims against the Contractor where liability is not otherwise set forth in the Contract as being "without limitation", and regardless of the basis on which the claim is made, Contractor's liability for direct damages, shall be the greater of $100,000, the dollar amount of the Contract, or two (2) times the charges rendered by the Contractor under the Contract. Unless otherwise specifically enumerated herein or in the work order mutually agreed between the parties, neither party shall be liable to the other for special, indirect or consequential damages, including lost data or records (unless the Contractor is required to back-up the data or records as part of the work plan), even if the party has been advised of the possibility of such damages. Neither party shall be liable for lost profits, lost revenue or lost institutional operating savings.

6. The State and Authorized User may, in addition to other remedies available to them at law or equity and upon notice to the Contractor, retain such monies from amounts due Contractor, or may proceed against the performance and payment bond, if any, as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against them.

E. Termination

1. Termination For Cause

The State may terminate this Contract for cause based upon the failure of Contractor to comply with the terms and/or conditions of the Contract; provided that the State shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) business days after receipt of such notice, the Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) business days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the State may, at its option, place the Contractor in default and the Contract shall terminate on the date specified in such notice. Failure to perform within the time agreed upon in the contract may constitute default and may cause cancellation of the contract.

Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the State to comply with the terms and conditions of this contract provided that the Contractor shall give the State written notice specifying the State agency's failure and a reasonable opportunity for the state to cure the defect.

2. Termination For Convenience

The State may terminate the Contract at any time without penalty by giving thirty (30) calendar days written notice to the Contractor of such termination or negotiating with the Contractor an effective date. Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

3. **Termination For Non-Appropriation Of Funds**
   The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract by the legislature. 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 of Title 39 of the Louisiana Revised Statutes of 1950 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 have not been appropriated.

F. Independent Assurances

Not Applicable

Attachments:

I. Certification Statement
II. LDH Standard Contract Form (CF-1)
III. HIPAA BAA
IV. Cost Template
V. Regional Map
VI. 2015 Required RSR Fields
VII. 2016 Required Part B Fields
VIII. Part B Program Monitoring Standards
IX. Part B Fiscal Monitoring Standards
X. PCN 1501 Treatment of Costs
XI. PCN 1304 Private Insurance
XII. PCN 1305 Premium Cost Sharing

Veteran-Owned And Service-Connected Small Entrepreneurships (Veteran Initiatives) And Louisiana Imitative 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.louisianaeconomicdevelopment.com/Account/Login

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:

ProposerStatusandReservedPoints

- 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.louisianaeconomicdevelopment.com/Account/Login . 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://wwwprd1.doa.louisiana.gov/osp/lapac/vendor/srchven.cfm. 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.

CERTIFICATION STATEMENT

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 complies with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein;.
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 technical and cost proposals are valid for at least ***90*** calendar days from the date of proposer's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have ***30*** calendar 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: Electronic or Photocopy Signature are NOT Allowed

Print Name:

Title:

LDH - CF - 1
Revised: 2016-09

Attachment III

CONTRACT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

LAGOV:
LDH:
Agency #

AND

FOR

☐ Interagency Personal Services Professional Services Consulting Services Social Services

INCLUDE RFP NUMBER (if applicable):

1) **Contractor (Registered Legal Name)**	5) **Federal Employer Tax ID# or Social Security # (Must be 11 Digits)**
2) **Street Address**	6) **Parish(es) Served**
City **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 **State** **Zip Code**	8a) **CFDA#**(Federal Grant #)

9) **Brief Description Of Services To Be Provided:**

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

12) **Maximum Contract Amount**

13) **Amounts by Fiscal Year**

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:

Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	First Name	Last 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 contract, the Contractor hereby agrees to the following terms and conditions:

1. **Discrimination Clause:** Contractor hereby agrees to abide by the requirements of the following as applicable: Titles VI and VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990; the Rehabilitation Act of 1973; Federal Executive Order 11246 as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Fair Housing Act of 1968; 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, sexual orientation, gender identity, age, national origin, disability, political affiliation, veteran status, or any other nonmerit factor. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable, shall be grounds for termination of this contract.

2. **Confidentiality:** 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. **Auditors:** 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, the Louisiana Department of Health, the 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 LDH 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 Louisiana Department of Health, 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 LDH Office**.

4. **Record Retention:** 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. **Record Ownership:** All records, reports, documents and other material delivered or transmitted to Contractor by the Department shall remain the property of the Department, and shall be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract. All 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 the Department, and shall, upon request, be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract.

6. **Non assignability:** 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 State Procurement.

7. **Taxes:** 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.

8. **Insurance:** 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 Louisiana Department of Health, 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.

9. **Travel:** 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.

10. **Political Activities:** 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.

11. **State Employment:** 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.

12. **Ownership of Proprietary Data:** 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.

13. **Subcontracting:** 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.

14. **Conflict of Interest:** Contractor warrants that 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.

15. **Unauthorized Services:** 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.

16. **Fiscal Funding:** 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 $2,000, the Division of Administration, Office of State Procurement.

    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. **State and Federal Funding Requirements:** Contractor shall comply with all applicable requirements of state or federal laws or regulations relating to Contractor's receipt of state or federal funds under this contract.

    If Contractor is a “subrecipient” of federal funds under this contract, as defined in 2 CFR Part 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), Contractor shall comply with all applicable requirements of 2 CFR Part 200, including but not limited to the following:

·Contractor must disclose any potential conflict of interest to the Department and the federal awarding agency as required by 2 CFR §200.112.
·Contractor must disclose to the Department and the federal awarding agency, timely and in writing, all violations of federal criminal laws that may affect the federal award, as required by 2 CFR §200.113.
·Contractor must safeguard protected personally identifiable information and other sensitive information, as required by 2 CFR §200.303.
·Contractor must have and follow written procurement standards and procedures in compliance with federally approved methods of procurement, as required by 2 CFR §§200.317 - 200.326.
·Contractor must comply with the audit requirements set forth in 2 CFR §§200.501 - 200.521, as applicable, including but not limited to:

- o Electronic submission of data and reports to the Federal Audit Clearinghouse (FAC) (2 CFR §200.512(d)).
- o Ensuring that reports do not include protected personally identifiable information (2 CFR §200.512(a)(2)).

Notwithstanding the provisions of paragraph 3 (Auditors) of these Terms and Conditions, copies of audit reports for audits conducted pursuant to 2 CFR Part 200 shall not be required to be sent to the Department.

18. **Amendments:** 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 the contract exceeds $2,000, by the Division of Administration, Office of State Procurement. 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.

19. **Non-Infringement:** 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 LDH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in LDH's name, but at Contractor's expense and shall indemnify and hold harmless LDH 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. **Purchased Equipment:** 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 LDH 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. **Indemnity:** Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, LDH, 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 R.S. 40:1237.1 et seq. provides malpractice 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 LDH.

22. **Severability:** 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. **Entire Agreement:** 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.

24. **E-Verify**: Contractor acknowledges and agrees to comply with the provision of R.S. 38:2212.10 and federal law pertaining to E-Verify in the performance of services under this contract.

25. **Remedies for Default**: Any claim or controversy arising out of this contract shall be resolved by the provisions of R.S. 39:1672.2-1672.4.

26. **Governing Law**: This contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana, including but not limited to R.S. 39:1551-1736; rules and regulations; executive orders; standard terms and conditions, and specifications listed in the RFP (if applicable); and this Contract.

27. **Contractor's Cooperation**: The Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the state when requested. This applies even if this Contract is terminated and/or a lawsuit is filed. Specifically, the Contractor shall not limit or impede the State's right to audit or shall not withhold State owned documents.

28. **Continuing Obligation**: Contractor has a continuing obligation to disclose any suspension or debarment by any government entity, including but not limited to the General Services Administration (GSA). Failure to disclose may constitute grounds for suspension and/or termination of the Contract and debarment from future contracts.

29. **Eligibility Status**: Contractor and each tier of Subcontractors, shall certify that it is not excluded, disqualified, disbarred, or suspended from contracting with or receiving federal funds or grants from the Federal Government. Contractor and each tier of Subcontractors shall certify that it is not on the List of Parties Excluded from Federal Procurement and Nonprocurement Programs promulgated in accordance with E.O.s 12549 and 12689, "Debarment and Suspension," as set forth at 24CFR Part 24, and "NonProcurement Debarment and Suspension" set forth at 2CFR Part 2424.

30. **Termination for Cause:** The Department may terminate this Contract for cause based upon the failure of the Contractor to comply with the terms and/or conditions of the Contract; provided that the Department shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) days after receipt of such notice, the Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the Department may, at its option, place the Contractor in default and the Contract shall terminate on the date specified in such notice. The Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the Department to comply with the terms and conditions of this contract; provided that the Contractor shall give the Department written notice specifying the Department's failure and a reasonable opportunity for the state to cure the defect.

31. **Termination for Convenience:** The Department may terminate this Contract at any time by giving thirty (30) days written notice to the Contractor. The Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

32. **Commissioner's Statements:** Statements, acts and omissions made by or on behalf of the Commissioner of Administration regarding the RFP or RFP process, this Contract, any Contractor and/or any subcontractor of the Contractor shall not be deemed a conflict of interest when the Commissioner is discharging her duties and responsibilities under law, including, but not limited, to the Commissioner of Administration's authority in procurement matters.

SIGNATURES TO FOLLOW ON THE NEXT PAGE

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 LOUISIANA DEPARTMENT OF HEALTH
SIGNATURE **DATE**	**SIGNATURE** **DATE**
NAME	**NAME**
TITLE	**TITLE**
SIGNATURE **DATE**	**SIGNATURE** **DATE**
NAME	**NAME**
TITLE	**TITLE**

Rev. 06/2016

HIPAA Business Associate Addendum

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

1. The Louisiana Department of Health ("LDH") is a Covered Entity, as that term is defined herein, because it functions as a health plan and as a health care provider that transmits health information in electronic form.
2. Contractor is a Business Associate of LDH, as that term is defined herein, because contractor either: (a) creates, receives, maintains, or transmits PHI for or on behalf of LDH; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for LDH involving the disclosure of PHI.
3. Definitions: As used in this addendum –
   a. The term "HIPAA Rules" refers to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 C.F.R. Parts 160 and 164, which were originally promulgated by the U. S.
      Department of Health and Human Services (LDHS) pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 and were subsequently amended pursuant to the Health Information Technology for Economic and Clinical Health ("HITECH") Act of the American Recovery and Reinvestment Act of 2009.
   b. The terms "Business Associate", "Covered Entity", "disclosure", "electronic protected health information" ("electronic PHI"), "health care provider", "health information", "health plan", "protected health information" ("PHI"), "subcontractor", and "use" have the same meaning as set forth in 45 C.F.R. § 160.103.
   c. The term "security incident" has the same meaning as set forth in 45 C.F.R. § 164.304.
   d. The terms "breach" and "unsecured protected health information" ("unsecured PHI") have the same meaning as set forth in 45 C.F.R. § 164.402.
4. Contractor and its agents, employees and subcontractors shall comply with all applicable requirements of the HIPAA Rules and shall maintain the confidentiality of all PHI obtained by them pursuant to this contract and addendum as required by the HIPAA Rules and by this contract and addendum.
5. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule or regulation (including the HIPAA Rules) or as otherwise required or permitted by this contract and addendum.
6. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this contract and addendum, including 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 LDH.
7. In accordance with 45 C.F.R. § 164.502(e)(1)(ii) and (if applicable) § 164.308(b)(2), contractor shall ensure that any agents, employees, subcontractors or others that create, receive, maintain, or transmit PHI on behalf of contractor agree to the same restrictions, conditions and requirements that apply to contractor with respect to such information, and it shall ensure that they implement reasonable and appropriate safeguards to protect such information. Contractor shall take all reasonable steps to ensure that its agents', employees' or subcontractors' actions or omissions do not cause contractor to violate this contract and addendum.
8. Contractor shall, within three (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. Disclosures which must be reported by contractor include, but are not limited to, any security incident, any breach of unsecured PHI, and any "breach of the security system" as defined in the Louisiana Database Security Breach Notification Law, La.R.S. 51:3071 *et seq*. At the option of LDH, any harm or damage resulting from any use or disclosure which violates this contract and addendum shall be mitigated, to the extent

practicable, either: (a) by contractor at its own expense; or (b) by LDH, in which case contractor shall reimburse LDH for all expenses that LDH is required to incur in undertaking such mitigation activities.

9. To the extent that contractor is to carry out one or more of LDH's obligations under 45 C.F.R. Part 164, Subpart E, contractor shall comply with the requirements of Subpart E that apply to LDH in the performance of such obligation(s).
10. Contractor shall make available such information in its possession which is required for LDH 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 LDH 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.
11. Contractor shall make PHI available to LDH upon request in accordance with 45 CFR § 164.524.
12. Contractor shall make PHI available to LDH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
13. 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 LDH available to the Secretary of the U. S. LDHS for purposes of determining LDH's compliance with the HIPAA Rules.
14. Contractor shall indemnify and hold LDH harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys' fees resulting from any violation of this addendum by contractor or by its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. The parties agree that the legal relationship between LDH and contractor is strictly an independent contractor relationship. Nothing in this contract and addendum shall be deemed to create a joint venture, agency, partnership, or employer-employee relationship between LDH and contractor.
16. Notwithstanding any other provision of the contract, LDH shall have the right to terminate the contract immediately if LDH determines that contractor has violated any provision of the HIPAA Rules or any material term of this addendum.
17. At the termination of the contract, or upon request of LDH, whichever occurs first, contractor shall return or destroy (at the option of LDH) 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 shall 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.

Attachment V

HEALTH INSURANCE PROGRAM COST TEMPLATE

Proposers must complete a cost proposal in the following format to be considered for award. Failure to complete will result in the disqualification of the proposal.

Instructions:
Proposal shall include all anticipated costs of successful implementation of all deliverables outlined in the RFP. Proposers shall provide one flat rate per deliverable for each Year in the table. This rate shall be fully burdened with all costs for the provision of services. Please complete these cost templates for each of the three years.

Year 1	
Premiums	
Cost Shares	
Administrative Costs	
Total	

Year 2	
Premiums	
Cost Shares	
Administrative Costs	
Total	

Year 3	
Premiums	
Cost Shares	
Administrative Costs	
Total	

Total for all three years $_____

HEALTH INSURANCE PROGRAM COST TEMPLATE

Proposers must complete a cost proposal in the following format to be considered for award. If it is not completed, the Proposer will be disqualified from consideration.

Instructions: Provide breakdown of the proposed Administrative costs above. Administrative costs may include usual and recognized overhead activities, facility costs, and the costs of management oversight of proposed activities under this HIP RFP. This can include 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. These costs should be added together and expressed as a percent of the direct costs (direct costs = proposed costs for the annual total of the health insurance premium payments and cost shares.) Please complete these cost templates for each of the three years.

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

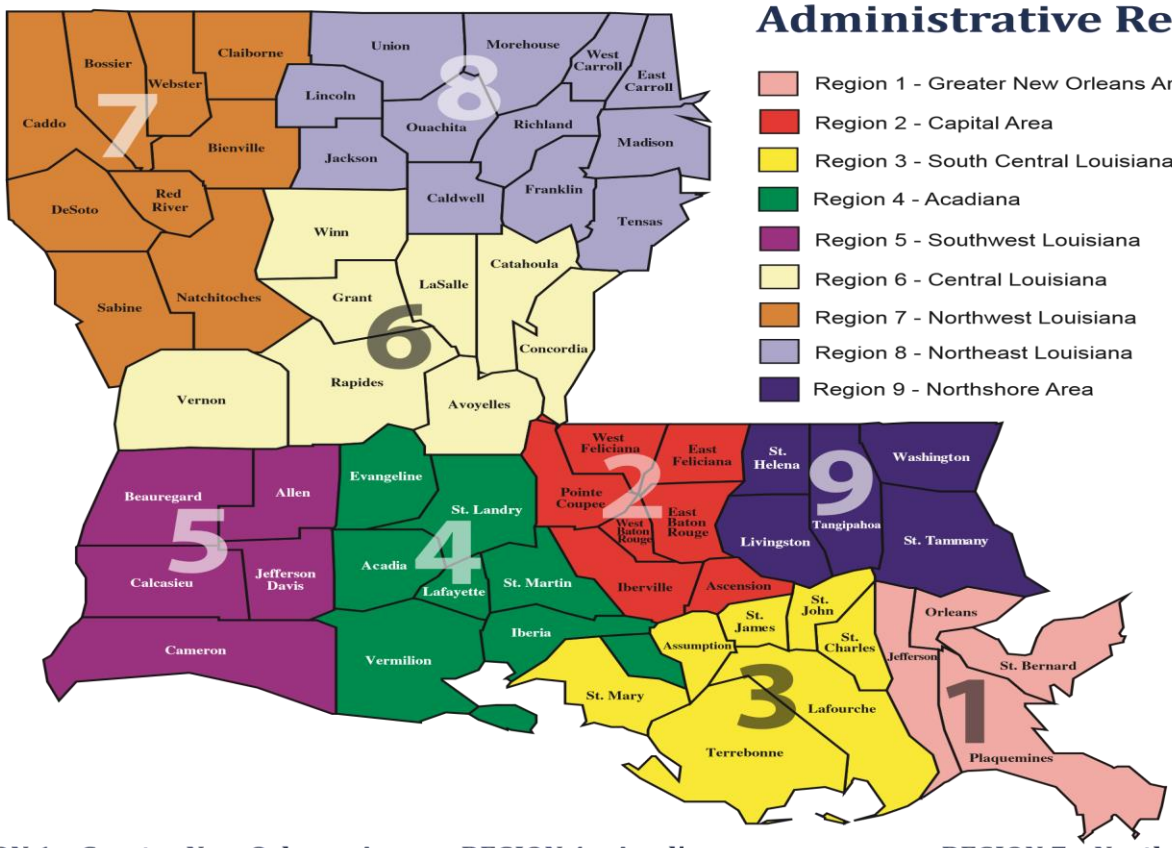
Year ___	Percent Effort (%)	Percent Year (%)	Total
Health Insurance Premiums			$
Health Insurance Cost Shares			$
Administrative Staff (list by position)			
			$
			$
			$
			$
Direct Labor Staff (list by position)			
			$
			$
			$
			$
			$
			$
Contracted Staff (list by position)			
			$
			$
			$
			$
Benefits			
			$

Travel/Professional Development			
			$
			$
			$
Operating Costs:			
Rent			$
Utilities			$
Telephone			$
Insurance			$
Other (List):			
			$
			$
Office Supplies (List)			
			$
			$
			$
Professional Services (list)			
			$
Other Direct Costs (list)			
			$
Year ___ Total			**$**

Attachment VI

Regional Map

LOUISIANA DEPARTMENT OF HEALTH



REGION 1 – Greater New Orleans Area
Benson Tower, 1450 Poydras St.,
10th Floor, New Orleans, LA 70112
Mail to: P.O. Box 1521
New Orleans, LA 70004-1521
PHONE: (504) 599-0606
FAX: 1-866-853-7278

REGION 2 – Capital Area
2521 Wooddale Blvd.
Baton Rouge, LA 70805
Mail to: P.O. Box 91248
Baton Rouge, LA 70821-9248
PHONE: (225) 925-6505
FAX: (225) 925-6525

REGION 3 – South Central Louisiana
1000-C Plantation Road
Thibodaux, LA 70301
PHONE: (985) 449-5163
FAX: (985) 449-5030

REGION 4 – Acadiana
117 Production Drive
Lafayette, LA 70508
Mail to: P.O. Box 81709
Lafayette, LA 70598-1709
PHONE: (337) 262-1231
FAX: (337) 262-1232

REGION 5 – Southwest Louisiana
One Lakeshore Drive, Suite 700
Lake Charles, LA 70629
Mail to: P.O. Box 3250
Lake Charles, LA 70602-3250
PHONE: (337) 491-2439
FAX: (337) 491-2785

REGION 6 – Central Louisiana
3600 Jackson St., Dunbar Plaza, Suite 113
Alexandria, LA 71303
Mail to: P.O. Box 13316
Alexandria, LA 71315-3316
PHONE: (318) 487-5147
FAX: (318) 484-2410

REGION 7 – Northwest Louisiana
3020 Knight St.– Suite 100
Shreveport, LA 71105
PHONE: (318) 862-9875
FAX: (318) 862-9701
TTD: (318) 862-9714 or
1-888-838-2351

REGION 8 – Northeast Louisiana
122 St. John St.
State Office Building, Room 110
Monroe, LA 71201-7384
PHONE: (318) 362-3066
FAX: (318) 362-3065

REGION 9 – Northshore Area
121 Robin Hood Drive
Hammond, LA 70403
PHONE: (985) 543-4216
FAX: (985) 543-4221

Attachment VII

2015 Required RSR Fields

Client-level Data Elements	Outpatient/ambulatory medical care	Medical case management	Oral healthcare	Early intervention services (A and B)	Home health care	Home and comm-based hlth serv	Hospice services	Medical nutrition therapy	Mental health services	Substance abuse services-outpatient	AIDS Pharmaceutical Assistance (local)	Health Insurance Program (HIP)	Case management (non-medical)	Child care services	Ped develop ass/early interv serv	Emergency financial assistance	Food bank/home-delivered meals	Health education/risk reduction	Housing services	Legal services	Linguistics services	Medical transportation services	Outreach services	Permanency planning	Psychosocial support services	Referral hlth care/support services	Rehabilitation services	Respite care	Substance abuse services-residential	Treatment adherence counseling	Rationale
Client Demographics																															
Year of birth	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,7
Ethnicity	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,4,7
Hispanic Subgroup	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,4,7
Race	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	4,7
Asian Subgroup	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	4,7
NHPI Subgroup	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	4,7
Gender	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
Transgender subgroup	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
Sex at Birth	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
Health insurance	•	•	•	•	•	•	•	•	•	•	•	•																			2,7
Housing status	•	•										•						•													2,7
Federal poverty level	•	•										•																			2,7
HIV/AIDS status	•	•										•																			2,4
Client risk factor	•	•										•																			7
Vital enrollment status	•	•										•																			5,6
HIV Diagnosis Year	•	•										•																			2,4
Client Demographics																															
HIV risk reduce screen/counseling	•																														2,3
First outpatient/ambulatory care visit	•																														2,3,4
Outpatient ambulatory care visits	•																														3,4
CD4 counts and dates	•																														3,4
Viral Load Counts and Dates	•																														3,4
Prescribed PCP prophylaxis	•																														3
Prescribed HAART	•																														3,4
Screened for TB since diagnosis	•																														3
Screened for syphilis	•																														3
Screened for Hep B since diagnosis	•																														3
Completed Hep B vaccine series	•																														3
Screened for Hep C since diagnosis	•																														3
Screened for substance use	•																														2,3
Screened for mental health	•																														2,3
Pap smear	•																														3,6
Pregnant	•																														2,3,4
Date of first Positive HIV Test	•																														1,3,4,5,6
Date of OAMC visit after first positive HIV test	•																														1,3,4,5
• report the data element																															

Field Requirements in LaCAN CAREWare

The following table summarizes the fields that are in LaCAN CAREWare. It also tells you whether the field is cross-provider (viewable/editable by all providers serving this client); whether the fields are required for the Medical or Non-Medical Ryan White Services Report (RSR), for LaCAN data collection (LA), and/or as a CAREWare function (CW); the frequency with which the data must be entered or submitted; and any corresponding notes.

DEMOGRAPHICS TAB									
Field Name	Cross-Provider	RSR Requirement		Required for		Frequency			Notes
		Clinical RSR	Non-Clinical RSR	Only Part B Agencies	All LaCAN Agencies	Enter w/in 5 days of change or enrollment	Enter w/in 30 days	Update every 6 months	
Last Name	✓	✓	✓		✓	✓			Use legal last name only. No nicknames, initials, or symbols. Refer to LaCAN Policies & Procedures for examples of how to enter names. Very important to have correct because it affects the URN.
First Name	✓	✓	✓		✓	✓			Use legal first name only. No nicknames, initials, or symbols. Do not use parent's name if entering child. Refer to LaCAN Policies & Procedures for examples of how to enter names. Very important to have correct because it affects the URN.
Middle Name	✓				✓	✓			Legal middle name only. Leave blank if client does not have middle name.
Birth Sex	✓	✓	✓		✓	✓			Male or Female. The sex client was assigned at birth. Does not affect URN, but is required for RSR.
Gender	✓	✓	✓		✓	✓			Male, Female, Trans FTM, Trans MTF, Trans Unknown. If a client does not identify as trans, use male or female as appropriate. Very important to have correct because it affects the URN.
Birth Date	✓	✓	✓		✓	✓			Legal date of birth only. Do not estimate.
Client ID									The confidential ID used to identify clients within the agency. For New Orleans Part A agencies, this is the UIN.
Address	✓				✓	✓		✓	Client's physical address. If client is homeless, put "homeless" and the date. E.g. "homeless 11-1-11"
City	✓				✓	✓		✓	City where client resides.
State	✓				✓	✓		✓	State required in CAREWare to generate the list of counties that apply to the state.
County	✓				✓	✓		✓	Parish where client resides.
Zip Code	✓	✓	✓		✓	✓		✓	Required for RSR and address. Only the first three digits of the zip codes are submitted with the RSR.
Ethnicity	✓	✓	✓		✓	✓			Client's self-reported ethnicity (Hispanic or non-Hispanic). See manual for further description.

Race	✓	✓	✓		✓	✓			Client's self-reported race. See manual for further description.
Ethnicity & Race Subgroups	✓	✓	✓		✓	✓			Client's self-reported race &/or ethnicity subgroups. See RSR manual for further description.
Vital Status	✓	✓	✓		✓	✓		✓	Client's current vital status (seen by all providers)
Deceased Date	✓	✓	✓		✓	✓		✓	Must enter date of death if 'Deceased' is selected for Vital Status.
Enrollment Status		✓	✓		✓	✓	✓	✓	Specific for each agency. Enter the client's current enrollment status at your agency. See manual for definitions.
Enrollment Date					✓		✓		Will need to enter an enrollment date the first time you enter a service for a client. This field will not need to be updated after that, unless you realize that there was an error. Should be the *first* time a client received services at your agency.
Case Closed Date					✓		✓		If client's case is closed, enter date of closure.
HIV Status	✓	✓	✓		✓	✓		✓	Use designations as described in the manual.
HIV + Date	✓				✓	✓		✓	Required in CAREWare if you select any of the following for HIV Status: HIV Positive (not AIDS), HIV Positive (AIDS status unknown), or CDC-defined AIDS
AIDS Date	✓	✓	✓		✓	✓		✓	Required in CAREWare if you select 'CDC-defined AIDS' for HIV Status. Only year of AIDS diagnosis is sent to HRSA
HIV Risk Factors	✓	✓	✓		✓	✓			Required by the RSR for ALL clients, even those whose HIV Status is 'Negative (affected)' or 'Unknown'
Common Notes	✓				✓	✓			Use this field to note when you make changes to common fields in the client record. Note date, agency, your name, and what was changed. Example: "11-05-11 @SLAC MT changed client address"

CLIENT INFORMATION TAB

Field Name	Cross-Provider	RSR Requirement		Required for		Frequency			Notes
		Clinical RSR	Non-Clinical RSR	Only Part B Agencies	All LaCAN Agencies	Enter w/in 5 days of change or enrollment	Enter w/in 30 days	Update every 6 months	
Consent to Mail	✓				✓	✓		✓	Select client's mailing preference. If client wishes to use a different mailing address, enter that address in the "Consented Mailing Address" text field.
Non-Logo Mailing Only	✓				✓	✓		✓	Check if only mail without the agency's logo should be sent to client.

Consented Mailing Address	✓				✓	✓		✓	If client wishes to receive mail at a different address than the one listed on their Demographic Tab (the physical address), enter the address here.
Case Management Program	✓				✓	✓			The client' current primary case management program. To be updated if the client changes programs. Example: Part B Medical Case Management.
Other Case Management Program	✓				✓	✓			Type other case management program here if selecting "Other" in Case Management Program field.
Case Manager Assigned: Part A	✓					✓			Name of current Part A case manager. Leave blank if client does not have Part A case manager.
Case Manager Assigned: Part B	✓			✓		✓			Name of current Part B case manager. Leave blank if client does not have Part A case manager.
Case Manager Assigned: Part D	✓					✓			Name of current Part D case manager. Leave blank if client does not have Part A case manager.
SSN	✓				✓	✓			Client's legal SSN. If client does not have a SSN, leave blank.
Primary Language	✓				✓	✓			The language the client is most comfortable speaking. If the client is most comfortable speaking Spanish and can only speak some English, put Spanish as their primary language.
Secondary Language	✓				✓	✓			Other language spoken by the client. Leave blank if not applicable.
Veteran	✓				✓	✓			Check this box if client is a veteran

EMERGENCY CONTACTS TAB

Field Name	Cross-Provider	RSR Requirement		Required for		Frequency			Notes
		Clinical RSR	Non-Clinical RSR	Only Part B Agencies	All LaCAN Agencies	Enter w/in 5 days of change or enrollment	Enter w/in 30 days	Update every 6 months	
EmergContact1 Name	✓				✓	✓			Name of client's first emergency contact
EmergContact1 Relationship	✓				✓	✓			Client's relationship to first emergency contact
EmergContact1 Aware of HIV Status	✓				✓	✓			Check if first emergency contact is aware of client's HIV status

EmergContact1 Auth to take kids	✓				✓	✓			Check if first emergency contact is authorized to take custody of client's children in emergency
EmergContact1 Address1	✓				✓	✓			First emergency contact's street address
EmergContact1 Address2	✓				✓	✓			First emergency contact's street address (2nd line if necessary)
EmergContact1 City	✓				✓	✓			First emergency contact's city
EmergContact1 State	✓				✓	✓			First emergency contact's state
EmergContact1 Zip Code	✓				✓	✓			First emergency contact's zip code
EmergContact1 Phone	✓				✓	✓			First emergency contact's phone
EmergContact1 Cell	✓				✓	✓			First emergency contact's cell phone number
EmergContact1 Email	✓				✓	✓			First emergency contact's email address
EmergContact1 Comments	✓								Comments or notes regarding emergency contact. (e.g. best times to contact, special instructions)
EmergContact2 Name	✓				✓	✓			Name of client's second emergency contact
EmergContact2 Relationship	✓				✓	✓			Client's relationship to second emergency contact
EmergContact2 Aware of HIV Status	✓				✓	✓			Check if second emergency contact is aware of client's HIV status
EmergContact2 Auth to take kids	✓				✓	✓			Check if second emergency contact is authorized to take custody of client's children in emergency
EmergContact2 Address1	✓				✓	✓			Second emergency contact's street address
EmergContact2 Address2	✓				✓	✓			Second emergency contact's street address (2nd line if necessary)
EmergContact2 City	✓				✓	✓			Second emergency contact's city
EmergContact2 State	✓				✓	✓			Second emergency contact's state
EmergContact2 Zip Code	✓				✓	✓			Second emergency contact's zip code
EmergContact2 Phone	✓				✓	✓			Second emergency contact's phone
EmergContact2 Cell	✓				✓	✓			Second emergency contact's cell phone number
EmergContact2 Email	✓				✓	✓			Second emergency contact's email address

EmergContact 2 Comments	✓								Comments or notes regarding emergency contact. (e.g. best times to contact, special instructions)
Emerg Evac Plan	✓					✓			Client's emergency evacuation plan (required for New Orleans agencies)

ANNUAL REVIEW & CUSTOM ANNUAL TABS

Field Name	Cross-Provider	RSR Requirement		Required for		Frequency			Notes
		Clinical RSR	Non-Clinical RSR	Only Part B Agencies	All LaCAN Agencies	Enter w/in 5 days of change or enrollment	Enter w/in 30 days	Update every 6 months	
Insurance Assessment Date	✓	✓	✓		✓	✓		✓	Insurance status is required to be assessed at least every 6 months.
Insurance Assessment: Primary Insurance	✓	✓	✓		✓	✓		✓	Insurance source used by the client for the majority of their medical care on the date of the insurance assessment. See manual for definitions and examples.
Insurance Assessment: Other Insurance	✓	✓	✓		✓	✓		✓	Do not need to complete if client only has one source of insurance (identified under Primary Insurance) or has no insurance (also identified under Primary Insurance). See manual for definitions and examples.
FPL Assessment Date	✓	✓	✓		✓	✓		✓	FPL (household size and income) is required to be assessed at least every 6 months.
FPL Assessment: Household Income	✓				✓	✓		✓	Total annual income of client and their spouse or blood relatives in the household. Required by CAREWare to calculate Poverty Level.
FPL Assessment: Household Size	✓				✓	✓		✓	Including client, the number of people living in the household who are either dependent upon the client or included in the above income. Required by CAREWare to calculate Poverty Level.
FPL Assessment: Poverty Level	✓	✓	✓		✓	✓		✓	Automatically calculated by CAREWare after Household Income and Household Size are entered.
Annual Screening: HIV Primary Care	✓				✓	✓			Type of clinic where client receives most of their HIV medical care.
Annual Screening: Housing/ Living Arrangements	✓	✓	✓		✓	✓		✓	Client's living arrangement this calendar year. See manual for examples and definitions of each type.
Annual Screening: HIV Risk	✓	✓	✓			✓			ONLY Ryan White-funded primary care providers are required to enter/update this for clients who received a RW-funded

Reduction Counseling & Counseled By									primary care visit during the 6-month period.
Annual Screening: Mental Health & Result	✓	✓	✓			✓			ONLY Ryan White-funded primary care providers are required to enter/update this for clients who received a RW-funded primary care visit during the 6-month period
Annual Screening: Substance Abuse & Result	✓	✓	✓			✓			ONLY Ryan White-funded primary care providers are require to enter/update this for clients who received a RW-funded primary care visit during the 6-month period
Education Level	✓				✓	✓			Client's highest education level this calendar year. Self-report.
Employment Status	✓				✓	✓			Client's employment status this calendar year.
Primary Income Source	✓				✓	✓			Client's primary income source this calendar year.
Primary Care Source	✓				✓	✓			Client's source of primary care (physician name or clinic name).
Number of children in HH	✓				✓	✓			Number of children (under 18 yrs) in client's household this calendar year.
Number of HIV+ children in HH	✓				✓	✓			Number of HIV+ children (under 18 yrs) in client's household this calendar year.
Annual Marital Status	✓				✓	✓			Client's marital status this calendar year.
Has client been incarcerated ?	✓				✓	✓			Client's incarceration status this calendar year.

SERVICES TAB

Field Name	Cross-Provider	RSR Requirement		Required for		Frequency			Notes
		Clinical RSR	Non-Clinical RSR	Only Part B Agencies	All LaCAN Agencies	Enter w/in 5 days of change or enrollment	Enter w/in 30 days	Update every 6 months	

Note: *if a client gives consent to share their information, all of the following fields (Date – Site) are automatically shared with the provider(s) authorized by the client.*

Some services will have additional custom service fields that appear depending on the service selected. Not all fields are listed below. Your grantee will provide you with a document listing additional fields to be completed per service name. Additional rows are provided below for you to fill in these fields if needed.									
Date (of service)		✓	✓		✓		✓		Date the service was provided. Information about services received by a client needs to be entered monthly. However, the date should be entered for each service a client received during that month. So if a client received case management on three different dates, each date would be entered separately.
Service Name		✓	✓		✓		✓		Select from list of contracted services. What appears in the list depends on what your agency is under contract for on the date of service.
Contract		✓	✓		✓		✓		The contract field will automatically be populated when you select a service. If multiple contracts are available, choose the contract that funded this client's service.
Units		✓	✓		✓		✓		Each agency will receive a spreadsheet that describes what to count as a unit (e.g., bus card, session, billable unit, etc.) for each type of service the agency provides. This is determined by each agency's contract with their grantee(s).
Price		✓	✓		✓		✓		Price will depend on how your agency is contracted to provide services and the reimbursement structure. Some services that are billed based on unit cost will have the unit cost set in CAREWare. Do NOT change the unit cost for these services.
Cost					✓		✓		The cost will automatically calculate for services with a unit rate (number of units x price= cost)
Staff or Provider Name					✓		✓		Select the name or agency that provided the service. For case management services, select the case manager.
Site					✓		✓		Site where the service was provided.

HIV/AIDS Bureau, Division of State HIV/AIDS Programs

National Monitoring Standards for Ryan White Part B Grantees: Program – Part B

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"On December 26, 2013, the Office of Management and Budget (OMB) published new guidance for Federal award programs, OMB Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Guidance), 2 CFR Part 200. The Guidance will supersede and streamline requirements from OMB Circulars A-21, A-87, A-110, A-122, A-89, A-102 and A-133 and the guidance in Circular A-50 on Single Audit Act follow-up. It is a key component of a larger Federal effort to more effectively focus Federal grant resources on improving performance and outcomes while ensuring the financial integrity of taxpayer dollars. Please note that the Uniform Guidance will not apply to grants made by the Department of Health and Human Services until adopted by HHS through a Federal Register Notice. That Notice, which will be published in late 2014, will indicate the date on which the Guidance applies to HHS grant funds. Until that time HRSA grantees must comply with the requirements in the current circulars listed above."

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Section A: **Allowable Uses of Part B Service Funds**				
1. Use of Part B funds only to support:	RFP, contract, MOU/LOA and/or statements of work	Include in RFP, contract, MOU/LOA and/or	• Provide the services described in the in	*[1]PHS ACT 2612 (a-d)

[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 "PHS ACT XXXX" and the section reference.

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
• Core medical services • Support services that are 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) • Clinical quality management activities • Planning and evaluation • Part B base services shall be provided through the following Part B Components: o HIV Consortia o Home and community based care o Provision of treatments o State Direct Services	language that describes and defines Part B services within the range of activities and uses of funds allowed under the legislation and defined in HRSA Policy Notices including core and support services, quality management activities, administration, and planning and evaluation	statements of work language that allows use of Part B funds only for the provision of services and activities allowed under the legislation and defined in referenced Policy Notices	RFP, contract, MOU/LOA and/or statements of work language • Bill only for allowable activities • Maintain in files, and share with the grantee on request, documentation that only allowable activities are being billed to the Part B grant	PHS ACT 2618 (4-5) HAB Policy Notices 97-01, 97-02, and 10-02 Dr. Parham-Hopson Letter 8/14/09, 4/8/10
Section B: **Core Medical-related**				PHS ACT 2612 (b)(1)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Services				
1. Provision of **Outpatient and Ambulatory Medical Care,** defined as the provision of 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	Documentation of the following: • Care is provided by health care professionals certified 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 HHS Guidelines • Service is not being provided in an emergency room, hospital or any other type of inpatient treatment center	• Include the definition, allowable services, and limitations of outpatient ambulatory medical services in the RFP, contract, MOU/LOA and/or statements of work language • Require subgrantees to provide assurances that care is provided only in an outpatient setting, is consistent with HRSA and HHS 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	• Ensure that client medical records document services provided, the dates and 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	PHS ACT 2612 (b)(3)(A)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
risk assessment, • Preventive care and screening • Practitioner examination, medical history taking, 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)				

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 Clinical Laboratory Improvement Amendments (CLIA) Program	• Include the HRSA approved service category 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 records to ensure requirements are met and match quantity of tests with reports	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 individual ordering the tests	HAB Policy Notice 07-02
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 eligibility determination criteria,	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 AdolescentsA medication formulary that meets the minimum requirements from all approved classes of medications according to PHS treatment guidelines.	Provide documentation that the ADAP program meets federal requirements, including: ○ 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	• 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, and low-	PHS ACT 2612 (b)(3)(B) PHS ACT 2616 HAB Policy Notice 07-03

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
income guidelines and Federal Poverty Level (FLP) threshold set by the State	• Policies and procedures to assure adherence to 5-10 percent of the State's total ADAP funding • An eligibility determination process requiring documentation in client medical records of low-income status and eligibility based on a specified percent of the FPL and proof of an individual's HIV-positive status, residency. • A process used to secure the best price available for all products including 340B pricing or better	that are FDA-approved ○ Use of Federal funds to match and expand the purchase of HIV medications and not displace State funding for the same purpose ○ 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	income status as defined by the State based on a specified percent of the FPL • 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	• Documentation that the (LPAP) program's drug distribution system has: ○ A client enrollment and eligibility determination	• Include a statement of need in the RFP, contract, MOU/LOA and/or statements of work language	• Provide to the Part B grantee, on request, documentation that the LPAP program meets HRSA/HAB	PHS ACT 2612 (b)(3)(C) *HAB plans to issue future guidance regarding this*

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
of HIV/AIDS medications using a drug distribution system that has: • A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum of every six months • A LPAP advisory board • Uniform benefits for all enrolled clients throughout the Consortium region • Compliance with Ryan White requirement of payer of last resort • Uniform benefits for all enrolled clients • A drug formulary approved by the local advisory committee/board • A recordkeeping system for distributed medications • A drug distribution system LPAP does not dispense	process that includes screening for ADAP and LPAP eligibility with rescreening every six months ○ A LPAP advisory board ○ Uniform benefits for all enrolled clients throughout the Consortium region ○ Compliance with Ryan White requirement of payer of last resort ○ A recordkeeping system for distributed medications ○ A drug distribution system that includes a drug formulary approved by the local advisory committee/board • 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	• Specify in the RFP, contract, MOU/LOA and/or statements of work language • all applicable federal, state, and local requirements for pharmaceutical distribution systems and the geographic area to be covered • Ensure that the program: ○ Meets federal requirements regarding client enrollment, uniform benefits, recordkeeping, and drug distribution process, consistency with current HIV/AIDS Treatment Guidelines, consistency with payer of last resort ○ Has consistent procedures/ systems that account for tracking and reporting of expenditures and income, drug pricing, client utilization, client eligibility and support	requirements • Maintain documentation, and make available to the Part B grantee on request, proof of client LPAP eligibility that includes HIV status, 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	*service category.*

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 requirements of the 340B Drug Pricing Program, Prime Vendor Program and/or Alternative Methods Project	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 5requirements of 340B Drug Pricing Program, Prime Vendor Program and/or Alternative Methods Project	clinical quality management ○ 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 files to ensure that distributed medications meet federal and contract requirements • Review client records to ensure proper enrollment, eligibility determination, uniform benefit, no dispensing of medications for unallowable purposes, no duplication of services		

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		• LPAPs need to be implemented in accordance with requirements of the 340B Drug Pricing Program, Prime Vendor Program and/or Alternative Methods Project in order to ensure "best Price" to maximize these resources.		
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	• Develop a RFP, contract, MOU/LOA, and/or 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 records and treatment plans for	• Maintain a dental file 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	PHS ACT 2612 (b)(3)(D)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	dollar amount, type of procedure, limitations on the number of procedures, or a combination of any of the above, as determined by the grantee	compliance with contract conditions and Ryan White program 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 ***Note:*** All four components must 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 the RFP, contract, MOU/LOA and/or statements of work 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 description of EIS services (funded through Ryan White or other sources) that 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	• 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	PHS ACT 2612 (b)(3)(E) PHS ACT 2612 (d) (1-2) *Additional policy guidance forthcoming, including expectations for Health education and literacy training, which are not covered in the legislation.*

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		• Specifies that services shall be provided at specific points of entry • Specifies required coordination with HIV prevention efforts and programs • Requires coordination 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	• Document referrals from key points of entry to EIS programs • 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, education, and 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	• 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	Include RFP, contract, MOU/LOA and/or statement of work language that: • Specify that Part B funding is to be used to supplement and not supplant existing federal, state, or local funding for Health	• 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	PHS ACT 2612 (b)(3)(F) PHS ACT 2615 HAB Policy Notice 10-02 Affordable Care Act of 2010

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
comprehensive primary care and pharmacy benefits for low income clients that provide a full 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[2]	to the costs of having the client in the ADAP program • Where funds are covering 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 State Ryan	Insurance Premium and cost-sharing assistance • Ensure an annual cost-benefit analysis that demonstrates the greater benefit of using Ryan White funds for Insurance/Cost-Sharing Program versus having the client on ADAP • Monitor provider 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 • Ensure RFP, contract, MOU/LOA and/or statement of work language contains clear directives on the payment of premiums, co-pays (including co-	policy provides comprehensive primary care and a formulary with a full range of HIV medications • 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	Dr. Parham-Hopson Letter 3/15/2011

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

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	White Program	pays for prescription eyewear for conditions related to HIV infection) and deductibles • Monitoring systems to check that funds are NOT 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 • Parenteral 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	• Specify in the RFP, contract, MOU/LOA and/or statement of work language clear definitions of services to be provided and staffing and licensure requirements • Review client records 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	PHS ACT 2612 (b)(3)(G)
9. Provision of **Home and Community-based Health Services,**	• Documentation that: ○ All services are provided based on a written care	• Specify in the RFP, contract, MOU/LOA and/or statement of work	• Ensure that written care plans with appropriate content and signatures	PHS ACT 2612 (b)(3)(J) PHS ACT 2614

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 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	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 the types of services needed and the quantity and duration of services ○ 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	language of 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 for the individual's HIV care • Review program files and client records 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 records to determine: ○ Services provided, dates, and locations ○ Whether services provided were allowable ○ Whether they were	are consistently prepared, included in client records, and updated as needed • Establish and maintain a program and client recordkeeping system to document the types 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 files and client records 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	

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
vaccinations for hepatitis co-infection, provided by public and private entities	health services Documentation of appropriate licensure and certifications for individuals providing the services, as required by local and state laws	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 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	• Documentation including the following: ○ Physician certification that the patient's illness is terminal as defined under Medicaid hospice	• Specify in the RFP, contract, MOU/LOA and/or statements of work language on allowable services, service standards,	• Obtain and have available for inspection appropriate and valid licensure to provide hospice care • Maintain and provide	PHS ACT 2612 (b)(3)(I) HAB Policy Notice 10-02

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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 • Mental health counseling • Physician services • Palliative therapeutics	regulations (having a life expectancy of 6 months or less) ○ Appropriate and valid licensure of provider as required by the State in which hospice care is delivered ○ Types of services provided, and assurance that they include only allowable services ○ 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	service locations, and licensure requirements • Review provider licensure to ensure it meets requirements of State in which hospice care is delivered • Review program files and client records to ensure the following: ○ Physician certification of client's terminal status ○ 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	the grantee access to program files and client records that include documentation of ○ Physician certification of clients terminal status ○ Services provided that are allowable under Ryan White and in accordance with the 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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	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 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,	• 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: ○ 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	• Specify in RFP, contracts, MOU/LOA, and/or statements of work 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 records to:	• Obtain and have on file and available for grantee review appropriate and valid licensure and certification of mental health professionals • Maintain client records that include: ○ A detailed treatment plan for each eligible client that includes required components and signature ○ Documentation of services provided, dates, and consistency with	PHS ACT 2612 (b)(3)(K)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
psychologists, and licensed clinical social workers	date, ○ Any recommendations for follow up ○ The signature of the mental health professional rendering service • Documentation of service provided to ensure that: ○ Services provided are allowable under Ryan White guidelines and contract requirements ○ Services provided are consistent with the treatment plan	○ Ensure the existence of a treatment plan that includes required components and signature ○ Document services provided, dates, and their compliance with Ryan White requirements and with the treatment plan	Ryan White requirements and with individual client treatment plans	
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, a client file is maintained that includes a physician's recommendation and a nutritional plan • Required content of the nutritional plan, including: ○ Recommended services and course of medical	• Specify in the RFP, contract, MOU/LOA and/or statements of work language: ○ 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	• Maintain and make available to the grantee copies of the dietitian's license and registration • Document services provided, number of clients served, and quantity of nutritional supplements and food provided to clients • Document in each client file: ○ Services provided and dates ○ Nutritional plan as required, including	PHS ACT 2612 (b)(3)(H) HAB Policy Notice 10-02

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	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, 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	provided through this service category ○ The required content of the nutritional plan • Review program files and client records for: ○ Documentation of the licensure and registration of the dietitian providing services ○ Documentation of services provided, including the quantity and number of 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	required information and signature ○ Physician's recommendation for the provision of food	

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		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 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	▪ 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 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	• Develop a RFP, contract, MOU/LOA and/or statement of work language that: ○ Clearly define medical case management services and activities and specify required activities and components ○ Specify required documentation to be included in client records • Review client records and service documentation to ensure compliance with contractual and Ryan 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	• 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 records that include the required elements for 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	PHS ACT 2612 (b)(3)(M) HAB Policy Notice 10-02

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• 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 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	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 ○ 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	management services • Obtain assurances and documentation showing that medical case management staff are operating as part of the clinical care team		

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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				
14. Support for **Substance Abuse Treatment 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	• 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 • Documentation through program files and client records that: ○ Services provided meet	• Develop an RFP and contracts that clearly 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	• 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	PHS ACT 2612 (b)(3)(L) HAB Policy Notice 10-02

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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 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	the service category definition ○ All services provided with Part B 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 • Assurance that services provided include a treatment plan that calls for only 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	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 files and client records for evidence of a treatment plan that specifies only 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 • For any client receiving acupuncture services	showing supervision by a physician or other qualified personnel • Provide assurance that all services are provided on an outpatient basis • Maintain program files and client records that include treatment plans with all required elements and document: ○ That all services provided are allowable under Ryan White ○ The quantity, frequency and 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	

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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	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	under this service category, documentation in the client file including: ○ 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	• 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	
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	PHS ACT 2612 (c)(1-2)
2. Support for **Case Management (Non-**	Documentation that: ○ Scope of activity includes	• Include in the RFP, contract, MOU/LOA	Maintain client records that include the required	Dr. Parham-Hopson Letter

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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 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	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, and other State or local health care and supportive services ○ 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	and/or statements of work language that: ○ Clear statement of required and optional case management services and activities, including benefits/ entitlement counseling, ○ Full range of allowable types of encounters and communications • Require in contract that client records 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 • Review client records and service documentation for compliance with contract requirements	elements as detailed by the grantee, including: ○ Date of encounter ○ Type of encounter ○ 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	8/14/09 HAB Policy Notice 10-02

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	such services are provided either as part of discharge planning or for individuals who are in the correctional system for a brief period			
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 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	• 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 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 ○ Where child care is provided by a neighbor, family member, or other person, payments do not	Develop the RFP, contract, MOU/LOA and/or statements of work language that: • clearly defines 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 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	Maintain documentation of: ○ Date and duration of each unit of child care service provided ○ Determination of client eligibility ○ Reason why child care was needed – e.g., client medical or other appointment or participation in a Ryan White-related meeting, group, or training session ○ 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	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 10-02

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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 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	include cash payments to clients or primary caregivers for these services ○ 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 ○ Any recreational and social activities are provided only in a licensed or certified provider setting	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 caregivers • Document that any recreational and social activities are provided only within a licensed or certified provider setting	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: ○ Documentation of compliance with grantee-required mechanism for handling payments for informal child 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	

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
			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 ***Note:*** Direct cash payments to clients are not permitted	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 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	• Develop the RFP, contract, MOU/LOA and/or statements of work language 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 category as required by the Ryan White Services Report (RSR) Review provider services and payment documentation to assure compliance with contractual and Ryan White programmatic requirements including:	• 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 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	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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		○ 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	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 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	• Documentation that: ○ Services supported are limited to food bank, home-delivered meals, 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, state and local regulations including any required licensure or certification for the	• Develop a RFP, contract, MOU/LOA and/or statements of work language that specify: ○ What types of services are to be supported – 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	• Maintain and make available to grantee documentation of: ○ Services provided by 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	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 10-02

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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	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	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 items	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	
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:	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	• Develop the RFP, contract, MOU/LOA and/or statements of work language that: ○ Define risk reduction counseling and provide guidance on the types of information, education, and	• Maintain, and make available to the grantee on request, records of services provided • Document in client records: ○ Client eligibility ○ Information provided on available medical and psychosocial	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09

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• 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	• 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	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	support services ○ Education about HIV transmission ○ Counseling on how to improve their health status and reduce the risk of HIV transmission	
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 family to gain or maintain medical care. Funds received under the Ryan White HIV/AIDS Program may be used for the following housing expenditures: • Housing referral services	• Documentation that funds are used only for allowable purposes: ○ The provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. • Housing-related referral services including housing assessment, search, placement, advocacy, and	• Develop RFP and contracts that clearly define and specify allowable housing-related services, including housing-related referrals, types of housing, and focus on short-term housing assistance • Review and monitor provider programs to: ○ Determine compliance with contract and program requirements	• Document: ○ Services provided including number of clients served, duration of housing services, types of housing provided, and housing referral services ○ Ensure staff providing housing services are case managers or other professionals who possess a	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 11– 01 76 FR 27649

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defined as assessment, search, placement, and advocacy services must be provided by case managers or other professional(s)who possess a comprehensive knowledge of local, state, and federal housing programs and how these programs can be accessed; or • Short-term or emergency housing defined as necessary to gain or maintain access to medical care and must be related to either: ○ Housing services that include some type of medical or supportive service: including, but not limited to, residential substance treatment or mental health services (not including facilities classified as an Institution for Mental Diseases under	the fees associated with them. • Housing related referrals are provided by case managers or other professional(s)who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs • For all housing, regardless of whether or not the service includes some type of medical or supportive services. ○ 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 ○ Housing services are essential for an individual or family to gain or	○ Ensure that housing referral services include housing assessment, search, placement, advocacy, and the fees associated with them ○ Ensure that housing related referrals are provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs ○ Ensure that clients receive assistance in obtaining stable long-term housing ○ Ensure that housing services are essential to maintaining or accessing HIV-related medical care and treatment ○ Ensure that Mechanisms are in place to allow newly	comprehensive knowledge of local, state, and federal housing programs and how to access those programs. • Maintain client records that document: ○ Client eligibility ○ Housing services, including referral services provided ○ Mechanisms are in place to allow newly identified clients access to housing services. ○ Individualized written housing plans are available, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services. ○ Assistance provided to clients to help them obtain stable long-term housing ○ Provide	

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Medicaid), residential foster care, and assisted living residential services; or ○ Housing services that do not provide direct medical or supportive services, but are essential for an individual or family to gain or maintain Access and compliance with HIV-related medical care and treatment; necessity of housing services for purposes of medical care must be certified or documented. • Grantees must develop mechanisms to allow newly identified clients access to housing services. • Upon request, Ryan White HIV/AIDS Program Grantees must provide HAB with an	maintain access and compliance with HIV-related medical care and treatment. ○ Mechanisms are in place to allow newly identified clients access to housing services ○ Policies and procedures to provide individualized written housing plan, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services. No funds are used for direct payments to recipients of services for rent or mortgages	identified clients access to housing services ○ Policies and procedures to provide individualized written housing plan, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services ○ Verify that no Ryan White funds are used for direct payment to clients for rent or mortgages	documentation and assurance that no Ryan White funds are used to provide direct payments to clients for rent or mortgages	

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individualized written housing plan, consistent with this Housing Policy, covering each client receiving short term, transitional and emergency housing services. • Short-term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term, stable living situation. • Housing funds cannot be in the form of direct cash payments to				

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recipients or services and cannot be used for mortgage payments. ***Note:*** Ryan White HIV/AIDS Program Grantees and local decision making planning bodies, *i.e.* Part A and Part B, are strongly encouraged to institute duration limits to provide transitional and emergency housing services. HUD defines transitional housing as 24 months and HRSA/HAB recommends that grantees consider using HUD's definition as their standard. .				
7. 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	• 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	• 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	• 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	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 10-02

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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 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 designed to ensure access to eligible benefits • 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	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	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	

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services eligible for funding under the Ryan White HIV/AIDS Program				
8. 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 a RFP, contract, MOU/LOA and/or statement of work that clearly describe: • 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 provided based on documented provider need in order for Ryan White clients to communicate with the provider and/or receive appropriate services	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 showing that interpreters and translators employed with Ryan White funds have appropriate training and hold relevant State and/or local certification	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09

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		○ Interpreters and translators have appropriate training and State or local certification		
9. 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 (through programs with insurance and other liability issues specifically addressed) • Purchase or lease of organizational vehicles	• 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 reimbursement that does not exceed the federal per-mile reimbursement rates ○ A system of volunteer drivers, where insurance and other liability issues	• Develop a RFP, contract, MOU/LOA and/or statement of work that clearly describe: ○ 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 receive vouchers or tokens rather than direct payments for	• Maintain program files that document: ○ 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 stated contract requirements with regard to methods of providing transportation: ○ Reimbursement methods do not	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 10-02

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for client transportation programs, provided the grantee receives prior approval for the purchase of a vehicle	are addressed ○ Purchase or lease of organizational vehicles for client transportation, with prior approval from HRSA/HAB for the purchase	transportation services • Monitor providers to ensure that use of funds meets contract and program requirements • Submit a prior approval request when the grantee or a provider is proposing the purchase or lease of a vehicle(s)	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 • Obtain grantee approval prior to purchasing or leasing a vehicle(s)	
10. Support for **Outreach Services** designed to identify individuals who	• Documentation that outreach services are designed to identify:	• Develop RFP and contracts that: ○ Provide a detailed	• Document and be prepared to share with the grantee:	Funding Opportunity Announcement

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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 quantified program reporting of activities and	○ 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: ○ 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 be quantified for program reporting and evaluation of effectiveness	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 monitoring and review for compliance with contract and program	○ 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 ○ To support broad-scope awareness activities	Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 07-06

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results to accommodate local evaluation of effectiveness ***Note:*** Funds may not be used to pay for HIV counseling or testing	• Documentation and assurance that outreach funds are not being used: ○ 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	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 duplicate HIV prevention outreach efforts	
11. 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-registered dietitian ***Note:*** Funds under this	• Documentation that psychosocial services funds are used only to support eligible activities, including: ○ 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-registered dietitian • Documentation that pastoral care/counseling services	• Develop RFP, contracts, MOU/LAO and/or statements of work 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: ○ Funds are being used only for allowable	• 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 supplements ○ Any pastoral care/counseling	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09 HAB Policy Notice 10-02

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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 affiliation	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	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	services meet all stated requirements	
12. Support for **Referral for**	• Documentation that funds	• Develop RFP, contracts,	• Maintain program files	Funding

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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:	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	MOU/LAO and/or statements of work that clearly specify: ○ 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	that document: ○ Number and types of referrals provided ○ Benefits counseling and referral activities ○ Number of clients served ○ Follow up provided • Maintain client records 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	Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09

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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		
13. 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, contracts, MOU/LOA, and/or statements of work 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	• 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 records that include the required elements as detailed by the grantee, including: ○ An individualized plan of care ○ Types of	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09

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		requirements • Review program and client records to ensure that: ○ Client has an individualized plan of care that includes specified components ○ Services provided are in accordance with the plan of care	rehabilitation services provided (physical and occupational therapy, speech pathology, low-vision training) ○ Dates, duration, and location of services	
14. 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	• 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	• Develop RFP, contracts, MOU/LOA, and/or statements of work 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: ○ Issues of liability have been addressed in a way that protects the client, provider, and Ryan White program ○ A mechanism is in	• Maintain, and make available to the grantee on request, program files including: ○ Number of clients served ○ Settings/methods of providing care • Maintain in each client file documentation of: ○ 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	Funding Opportunity Announcement HAB Policy Notice 10-02

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clients or primary caregivers	payment to clients or primary caregivers ○ Payments provide reimbursement for actual costs without over payment, especially if using vouchers or gift cards	place to ensure that no cash payments are made to clients or primary caregivers ○ Payment made is for reimbursement of actual costs, especially if using vouchers or gift cards	arrangements are used: ○ 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	
15. 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	• 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	• Develop RFP, contracts, MOU/LOA, and/or statements of work that 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	• 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	Funding Opportunity Announcement HAB Policy Notice 10-02

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qualified personnel with 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	accordance with a 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	○ Requirements for a treatment plan including specified elements ○ What information 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 files and client records for evidence of a treatment plan with the required components • For any client receiving acupuncture services under this service	by a physician or other qualified personnel • Provide assurance that all services are provided in a short-term residential setting • Maintain program files that document: ○ That all services provided are allowable under this service category ○ The quantity, frequency, and modality of treatment services • Maintain client records 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:	

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		category, documentation in the client file including: ○ Caps on use of Ryan White funds ○ 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	○ A written referral from the primary health care provider ○ The quantity of acupuncture services provided	
16. 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, contracts, MOU/LOA, and/or statements of work that 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	• Provide assurances and maintain documentation that: ○ 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 records that include the	Funding Opportunity Announcement Dr. Parham-Hopson Letter 8/14/09

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		must be documented in each client's file and reported to the grantee • Monitor provider and review client records to ensure compliance with contractual and program requirements	required elements as detailed by the grantee	
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 HHS 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	• 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 service category definition for each funded service • Review of CQM program to ensure that both the grantee	• Develop, implement, and monitor a Quality Management Plan • Specify in RFPs, contracts, MOU/LOA and/or statements of work language on the grantee's quality-related expectations for each service category • Conduct chart (client record) reviews and visits to provider/subgrantees to monitor compliance with the Quality Management Plan and with Ryan White Program quality expectations • Provide a written Assurance signed by the	Participate in quality management activities as contractually required; at a minimum: • Compliance with relevant service category definitions • Collection and reporting of data for use in measuring performance	PHS ACT 2618 (b)(3)(C&E)

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HIV health services CQM program to include: • A Quality Management Plan • Quality expectations for 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 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*	and providers are carrying out necessary CQM activities and reporting CQM performance data • Develop and monitor own Standards of Care as part of CQM Program	Chief Elected Official that the Quality Management Program meets HRSA requirements		
Section E: **Administration**				
1. **Administration:** Grantees are to spend no more than 10% percent of grant funds	• Documentation that grantee administrative costs paid by Part B funds, including planning and evaluation	• Document, through job descriptions and time and effort reports, that the activities defined in		Notice of Award PHS ACT 2618 (b)(2-4)

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on planning and evaluation activities, not more than 10% on administration and, when combined, not more than 15% on planning, evaluation and 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	costs, are not more than 15% of total grant funds • Review of activities to ensure the proper categorization of allowable administrative functions	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 activities defined as administrative in nature are included in other Part B budget categories • Provide HRSA/HAB with current operating budgets that include sufficient detail to review administrative expenses		Part B Manual

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programmatic and financial reports • Compliance with grant conditions and audit requirements • Activities associated with the grantee's contract award procedures including: o The development of requests for proposals RFPs, contracts, MOU/LOA, and/or statements of work o 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				

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Note: Please see Part B Fiscal Monitoring Standards for additional information on use of funds for administration				
Section F: **Other Service Requirements**				
1. **WICY – Women, 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 ***Note:*** *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	• Documentation that the 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 • 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	• Track and report the 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	Track and report to the grantee the amount and percentage of Part B funds expended for services to each priority population	Dr. Joseph F. O'Neill Letter 8/10/2000 Doug Morgan Letter 6/17/03 Funding Opportunity Announcement
2. **Referral relationships with key points of entry:** Requirement that	Documentation that written referral relationships exist between Part B service	• Require in RFP, contracts, MOU/LOA, and/or statements of	• Establish written referral relationships with specified points of	PHS ACT 2617 (b)(7)(G)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 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 A, C and D and F grantees	providers and key points of entry	work 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 records to determine whether referral relationships are being used	entry • Document referrals from these points of entry	
Section G: **Prohibition on Certain Activities**				

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 RFP, contracts, MOU/LOA, and/or statements of work, 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 activities	• 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 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	Notice of Award PHS ACT 2684

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 measure/method, grantee responsibility and provider/subgrantee responsibility 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 geographic areas and/or disproportionately affected populations rather than targeting the general public	• 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
4. **Lobbying Activities:** Prohibition on the use of Ryan White funds for influencing or	• Implementation of actions specified in G.1 above • Review of lobbying certification and disclosure	• Carry out actions specified in G.1 above • File a signed "Certification Regarding	• Carry out subgrantee actions specified in G.1 above • Include in personnel	[3]45 CFR 93 Conditions of Grant Award

[3] References to the Code of Federal Regulations will be abbreviated as "CFR" throughout this document

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
attempting to influence members of Congress and other Federal personnel	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	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	manual and employee orientation information on regulations that forbid lobbying with federal funds	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 and nutrition) • Review of expenditures by subgrantees to ensure that no cash payments were made to individuals	• 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	PHS ACT 2618 (b)(6) HAB Policy Notice 10-02

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 RFP, contracts, MOU/LOA, and/or statements of work 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

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 RFP, contracts, MOU/LOA, and/or statements of work	• 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 Dr. Parham Hopson Letter 1/6/2012
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	• 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 PHS ACT 2618 (b)(6) Dr. Parham-Hopson Letter 12/2/10

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
• Off-premise social/recreational activities or payments for 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. b. Participants to include individuals with HIV/AIDS, members of	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	PHS ACT 2617 (b)(7)(A)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Federally recognized Indian tribe as represented in the State, representatives of grantees under each part under this Part, providers, and public agency representatives				
2. Access to Care a. 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	PHS ACT 2617 (b)(7)(G)
b. Provision of Part B-funded HIV primary medical care and support services, to the maximum extent	• Documentation that the EMA/TGA is funding HIV Primary medical care and support services • Documentation that agency	• Include language in RFP, contracts, MOU/LOA, and/or statements of work regarding access to care	N/A	PHS ACT 2617 (b)(7)(B

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
possible, without regard to either: • The ability of the individual to pay for such services, or • The current or past health conditions of the individuals to be served	billing and collection policies and procedures are in place that do not: ○ Deny services for non-payment ○ Deny payment for inability to produce income documentation ○ Require full payment prior to service ○ Include any other procedure that denies services for non-payment ○ Permit denial of services due to pre-existing conditions ○ Permit denial of services due to non-HIV-related conditions ○ Provide any other barrier to care due to a person's past or present health condition	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, 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 subgrantees dropping high risk or high cost clients including "dumping" or "cherry picking" of patients		

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
c. 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 accessible • Providers have in place policies and procedures that provide transportation if 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	• Specify in RFP, contracts, MOU/LOA, and/or statements of work 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 access to public transportation • Review policies and procedures for providing transportation assistance if facility is not accessible by public transportation	N/A	PHS ACT 2617 (b)(7)(B)
d. 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: ○ Brochures ○ Newsletters ○ Posters ○ Community Bulletins ○ Any other types of promotional materials • Documentation that any	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	PHS ACT 2617 (b)(7)(b)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	funded awareness activities target specific groups of low-income individuals with HIV disease to inform them of such services			
3. Expenditure and Use **of Funds** a. Compliance with statutory requirements regarding the timeframe for obligation and expenditure of funds, and with any cancellation of unobligated funds	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 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	Inform the grantee of any expected under-expenditures as soon as identified	PHS ACT 2618 (c-d) PHS ACT 2622 (a-d)
b. Expenditure of funds for core medical services, support services	Documentation of the grantee's expenditure of funds for core medical services,	• Establish and maintain systems and procedures that ensure that funds	N/A	PHS ACT 2612

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
approved by the Secretary of HHS, and administrative expenses only	support services approved by the Secretary of HHS, and administrative expenses only	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		
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	N/A	PHS ACT 2612 (a-d) PHS ACT 2618 (c-d)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		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 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		

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		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 such area with HIV/AIDS to the general population in such area with HIV/AIDS, unless a waiver from this provision is obtained	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 • 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	• Prepare and submit the annual WICY Report • Submission of a WICY Waiver when needed	N/A	PHS ACT 2612 (e)
e. Compliance with legislative requirements regarding the Medicaid	Documentation that funded providers providing Medicaid-reimbursable services either:	Specify in RFP, contracts, MOU/LOA, and/or statements of work that	• Maintain on file documentation of Medicaid Status and	

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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	• 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	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	that the provider is able to receive Medicaid payments Document efforts and timeline for certification if in process of obtaining certification	
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	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	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	PHS ACT 2617 (E) HAB Policy Notice 11-02

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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	expenditures			
g. Procedures in place to ensure that services 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	• Documentation that program services are being 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	• Review and monitor the licensing and certification 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	N/A	DSS Policy Guidance No. 4 Clarification of Legislative Language Regarding Contracting with For Profit Entities 6/1/2000 HAB Policy Notice 11-02
h. Funded services to be	Documentation that funded	• Specify in RFP,	N/A	PHS ACT 2681 (c)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
integrated with other such services and coordinated with other available programs (including Medicaid), so that the continuity of care and prevention services for individuals with HIV is enhanced	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 RFP, contracts, MOU/LOA, and/or statements of work and standards of care	contracts, MOU/LOA, and/or statements 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 continuum of care and ways the entities are integrated and coordinated		
4. 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	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	• Clearly define administrative cost caps and allowable activities in the RFP, contracts, MOU/LOA, and/or statements of work • Monitor subgrantee expenditures to ensure that: ○ They meet the legislative definition of	N/A	PHS ACT 2612 (a-d) PHS ACT 2618 (b-d) HAB Policy Notices 97-01, 97-02, and 10-02 Dr. Parham-

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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	dollars • Both grantee and subgrantee administrative expenditures meet the legislative definition of administrative activities	administrative activities ○ 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		Hopson Letter 8/14/09, 4/8/10
b. Implementation of a Clinical Quality Management (CQM) program that meets HRSA requirements, with funding that does not exceed the lesser of 5% of total grant funds or $3 million	Documentation that: • The grantee has 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 and implement a CQM plan • Develop a CQM budget and separately track CQM costs • Provide a budget and a financial report to HRSA that separately identify all CQM costs	N/A	PHS ACT 2618 (b)(E)
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 RFP, contracts, MOU/LOA, and/or statements 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***	N/A	PHS ACT 2618 (b)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		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		
c. 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 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	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 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	• 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 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	N/A	PHS ACT 2617 (b)(7)(F)
d. No use of Part B funds for AIDS programs, or	***[See Section G.I, Drug Use and Sexual Activity]***	***[See Section G.I, Drug Use and Sexual Activity]***	N/A	PHS ACT 2684

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
for development of materials, designed to promote or encourage, directly or indirectly, intravenous drug use or sexual activity, whether homosexual or heterosexual				
5. Miscellaneous a. Compliance with the statutory requirements regarding the imposition of charges for services, for those providers who charge for services	Refer to fiscal monitoring standards	Refer to fiscal monitoring standards	N/A	PHS ACT 2617
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		PHS ACT 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 RFP, contracts, MOU/LOA, and/or statements of work the requirement that the State and its subcontractors will cooperate with any Federal investigation regarding the		PHS ACT 2617 (b)(7)(D)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		Part B Grant		
Section I: **Minority AIDS Initiative**				
Reporting Submission of an Annual Plan 60 days after the budget start date or as specified on the Notice of Award 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: • Dollars expended • Number of clients served • Units of service overall and by race and ethnicity, women, infants, children, youth • Client-level outcomes	Part B Minority AIDS Initiative (MAI) Reporting Instructions
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	Part B Minority AIDS Initiative (MAI) Reporting Instructions

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
			Report	
Section J: **Data Reporting Requirements**				
1. Submission of the **Ryan 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	Documentation that the State 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	• Review the State's 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	N/A	Ryan White 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	Ensure providers are entering client-level data,	• Maintain client-level data on each client	Ryan White HIV/AIDS Program Services Report

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	sections of the online client report	timely, accurately and completely.	served, including in each client record demographic status, HIV clinical information, HIV-care medical and support services received, and the client's Unique Client Identifier • Submit this report online as an electronic file upload using the standard format • Submit both interim and final reports by the specified deadlines	Instruction Manual
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	• 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	• 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: ○ information on the geographic region to be served and how they are affected by	• 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	PHS ACT 2613 PHS ACT 2613(a)(1) PHS ACT 2613 (f)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
providers or organizations may be designated consortia if such entities are the only available providers of quality HIV care in an area	that the for-profit entity is the only quality provider of care within the consortium area	HIV/ADS ○ A listing of the HIV/AIDS service providers operating within the region and their government or nonprofit status • Obtain assurances from 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	assurances to the State in cases where a private for-profit organization is the only quality provider of care within the consortium area	
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	Documentation through program files and client records 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	• Develop RFP, contracts, MOU/LOA, statements of work and/or consortium agreements that: ○ Clearly define allowable consortium activities ○ Specify required documentation to be included in client records and	• Maintain, and share with the grantee upon request, program and financial records that document: ○ Types of services provided ○ Use of funds only for allowable services ○ Assurances and agreements between	PHS ACT 2613

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 dollars that may be expended for such services	All services provided or contracted through a consortium are counted as support services	consortium administrative files • Review client records and service documentation to ensure compliance with contractual and Ryan White programmatic requirements • Review assurances and agreements for the 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	consortium and providers • Maintain client records that include the required elements as detailed by the grantee	
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	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	• Provide guidance to consortia through RFP, contracts, MOU/LOA, and/or statements of work on the need to submit the required assurances to the State in order to receive Part B funding • Obtain from consortia	Sign assurances and submit to the State as required in order to receive Part B funds	PHS ACT 2613 (b)(1)(A-C) PHS ACT 2613 (b)(2)(A-B)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 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	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 entity that will integrate the delivery of services among the identified populations and subpopulations	the appropriate signed assurances as part of the annual funding cycle		

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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				
4. Consortia to be required 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	Review of each consortium 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	Develop an application 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	Submit to the State an application that provides specific documentation that demonstrates the service record and representativeness of consortium agencies and community-based organizations	PHS ACT 2613 (c)(1)(A)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 individuals with HIV/AIDS in the needs assessment process	• Develop clear guidelines, RFP, contracts, MOU/LOA, and/or statements of work with consortia that specify the requirements for consortium needs assessments, including participation of individuals with HIV/AIDS • Review needs assessment documents to ensure that requirements are met	• 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, 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	PHS ACT 2613 (c)(1)(B)
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	• A service plan description for each consortium providing documentation and assurances that the service plan addresses service needs and: ○ Specifies that service needs will be addressed through the coordination and expansion of existing programs before	• 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 ○ Coordination and expansion of existing	• 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	PHS ACT 2613 (c)(1)(B-C) PHS ACT 2613 (c)(1)(F)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
• 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 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	new programs are created ○ Provides for geographic service areas in metropolitan areas that correspond, to the extent practicable, to boundaries of local health and support service delivery systems ○ Ensures that rural case management services link available community support services to specialized HIV medical services ○ Ensures the participation of individuals living with HIV/AIDS in needs assessment and service planning • Documentation of adequate planning to: ○ Meet the special needs for of families with HIV/AIDS, including family- and youth-centered HIV care services ○ Address disparities in access and services and historically underserved	programs ○ Use of common service boundaries in urban areas ○ 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 service planning	HIV/AIDS • Provide specified written assurances to the State	

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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	communities			
7. **Consultation** by each consortium with representatives of required entities in the 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	Documentation in each consortium's service plan that the establishment of the service plan involved 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	• Provide guidance to consortia through RFP, contracts, MOU/LOA, and/or statements of work that 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	Maintain, and provide to the grantee on request, documentation that shows the involvement of the required representatives in the development of the service plan for the consortium region, such meeting dates, minutes, agendas, and attendance lists	PHS ACT 2613 (c)(2)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 planning council	• Diverse entities like those included as members of Part A HIV health services planning councils			
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	• 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	• Provide clear guidance to consortia in RFP, contracts, MOU/LOA, and/or statements of work regarding evaluation requirements, including: ○ Legislative requirements for evaluation ○ State timetables and other guidelines for evaluation, such as a multi-year evaluation plan and description of what evaluation	• 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,	PHS ACT 2613 (c)(1)(D-E)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
methodology information needed for the State to conduct an independent evaluation	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 the State to conduct independent 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	for review and for use in conducting 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	Documentation of: • State efforts and methods used to raise awareness of the ADAP program to individuals with HIV/AIDS	• Specify in RFP, contracts, MOU/LOA, and/or statements of work the requirement to provide outreach	• Document and make available to the State for inspection and review efforts to provide outreach (awareness)	PHS ACT 2616 (c)(3-5)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
of such individuals regarding the State ADAP Program to facilitate access to treatments for such individuals and to document progress in making therapeutics available	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	(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 of access and enrollment in ADAP by target populations	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	
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	• 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	• Specify in RFP, contracts, MOU/LOA, and/or statements of work 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	• 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	PHS ACT 2616 (g) HAB Policy Notice 07-02

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 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	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 •	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 Part B or ADAP activities • Develop and implement a plan for the use of drug rebate funds to support additional Part B or ADAP activities	to apply such funds	

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 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"	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 ADAP and CMS • Amount of ADAP funds used to cover TrOOP expenses for clients on Medicare Part D	• Develop and implement necessary data systems for tracking and reporting Part B payments • Participate in data sharing with the CMS COB contractor • Sign a data sharing agreement with CMS and submit electronic enrollment files with 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		Dr. Parham-Hopson Letter 11/23/10 The Affordable Care Act, Public Law 111-148, Section 3314

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		• Monitor expenditures and reporting to ensure that: ○ 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 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	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 of the HIV-related services provided in the State to individuals and families with HIV/AIDS during the previous year	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 the State during the previous year		PHS ACT 2617 (a) PHS ACT 2617 (b)(1) Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
provided in the State to individuals and families with HIV/AIDS during the previous year				
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 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)	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 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	• 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 • 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	N/A	PHS ACT 2617 (b)(2-3) Funding Opportunity Announcement Ryan White Needs Assessment Guide

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		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 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	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 • 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	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		PHS ACT 2617 (b) (4) Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 allocation of funds • 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	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	PHS ACT 2617 (b)(5)(A-G)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 (SCSN) • Key outcomes to be measured by all entities that receive funding under the Ryan White Part B program				

Attachment X

HIV/AIDS Bureau, Division of State HIV/AIDS Programs National Monitoring Standards for Ryan White B Grantees: Fiscal – Part B

Table of Contents

Section A: Limitation on Uses of Part B Funding
Section B: Unallowable Costs
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Section M: Tracking and Reporting Use of Rebates

"On December 26, 2013, the Office of Management and Budget (OMB) published new guidance for Federal award programs, OMB Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Guidance), 2 CFR Part 200. The Guidance will supersede and streamline requirements from OMB Circulars A-21, A-87, A-110, A-122, A-89, A-102 and A-133 and the guidance in Circular A-50 on Single Audit Act follow-up. It is a key component of a larger Federal effort to more effectively focus Federal grant resources on improving performance and outcomes while ensuring the financial integrity of taxpayer dollars. Please note that the Uniform Guidance will not apply to grants made by the Department of Health and Human Services until adopted by HHS through a Federal Register Notice. That Notice, which will be published in late 2014, will indicate the date on which the Guidance applies to HHS grant funds. Until that time HRSA grantees must comply with the requirements in the current circulars listed above."

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Section A: **Limitation on Uses of Part B funding**				
1. For grantees without a fiduciary intermediary or administrative agent:	• Identification and description of all expenses within grantee budget that are	• Identify and appropriately categorize administrative	N/A	[1]PHS ACT 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 "PHS ACT XXXX" and the section reference.

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Adherence to 10% limit on proportion of federal funds spent on administrative costs in any given grant year	categorized as administrative costs • Documentation that administrative expenses do not exceed 10% of the awarded 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. For grantees with a fiduciary intermediary or administrative agent: Adherence to 15% limit on proportion of federal funds spent on grantee administration and planning and evaluation in any given grant year	• 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 the awarded 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%		PHS ACT 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 administration	Provide to HRSA current operating budgets and allocation expense reports with sufficient detail to review administrative expenses	N/A	PHS ACT 2618(b)(3)(C)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	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, MOA/MOU, subgrantee and contract proposal review activities, negotiation and awarding of contracts • Monitoring activities including telephone consultation, written documentation, and onsite visits • Reporting on contracts, and funding reallocation activities • Indirect costs			

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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	PHS ACT 2617(b)(3)(B) Harold Phillips & Steven Young Letter, 7/17/2012 http://hab.hrsa.gov/manageyourgrant/files/rent2013.pdf
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 this title, including program coordination; clerical, financial, and management staff not directly related to	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	PHS ACT 2618(b)(3)(D) Funding Opportunity Announcement Harold Phillips & Steven Young Letter, 7/17/2012 http://hab.hrsa.gov/manageyourgrant/files/rent2013.pdf 2 CFR Part 215

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 Circular 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 **Note 1:** To obtain a rate through HHS's Division of Cost Allocation (DCA), visit DCA's website at: http://rates.psc.gov/ **Note 2:** Indirect costs are still subject to the Ryan White Part B administrative cost caps	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 Officer	• 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 and adherence to the 10% administration cap • Review subgrantee budgets to ensure no duplication of cost covered in indirect 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 Circular A-87 Appendix A Chapter II 2 CFR 230 (E) or OMB Circular 122 Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		and other line item expenses		
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 quality management	N/A	PHS ACT 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, subgrantee 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	Report to the grantee expenses by service category	PHS ACT 2618 (c)(1-2) PHS ACT 2612(b)(1-2) Notice of Award HRSA HAB Policy Notice 08-02

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		for the tracking of core medical services expenses • Grantees may request a core service waiver		
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, subgrantee 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 reporting that documents expenditures by	• Report to the grantee expenses by service category • Document that support service funds are contributing to positive medical outcomes for clients	PHS ACT 2613 (a)(2)(B); PHS ACT 2613(f)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		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	PHS ACT 2616 (c)(6)
Section B: **Unallowable Costs**				
1. The grantee shall provide to all Part B subgrantees definitions of allowable costs	• Signed contracts, grantee and subgrantee assurances, and/or certifications that define and specifically forbid	• Document receipt of the Notice of Award and maintain a file of signed assurances	• Maintain a file with signed subgrantee agreement, assurances, and/or certifications that	HAB Policy Notice 10-02 PHS Act 2684

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	the use of Ryan White funds for unallowable expenses • Grantee review of subgrantee budgets and expenditures to ensure that they do not include any unallowable costs ***Note:*** Unallowable costs are listed in this section of the National Monitoring Standards	• 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, subgrantee 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	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	Notice of Award HAB Policy Notice 07-06 Part B Manual HHS Grants Policy Statement
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	PHS ACT 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 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 prohibit cash payments to service recipients	• Carry out subgrantee actions specified in B.1 above • Maintain documentation of policies that prohibit use of Ryan White funds for cash payments to service recipients	PHS ACT 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	PHS ACT B 2684
5. No use of Part B funds for the purchase of vehicles without written Grants Management Officer (GMO) approval	• Implementation of actions specified in B.1 above • Where vehicles were purchased, review of files for written permission from GMO	• Carry out actions specified in B.1 above • If any vehicles were purchased, maintain file documentation of permission of GMO to purchase a vehicle	• Carry out subgrantee actions specified in B.1 above • If vehicle purchase is needed, seek grantee assistance in obtaining written GMO approval and maintain document	Notice of Award

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
			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 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 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 • Review program plans and budget narratives for outreach activities that have HIV prevention education as their exclusive purpose	• 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 Policy 97-01
8. No use of Part B funds for influencing or attempting to influence members of Congress and other Federal personnel	• Implementation of actions specified in B.1. above • Review lobbying certification and disclosure forms for both the grantee and	• Carry out actions specified in B.1. above • File a signed "Certification Regarding Lobbying", and, as	• Carry out subgrantee actions specified in B.1 above • Include in personnel manual and employee	[2]45 CFR 93 Notice of Award Dr. Parham-

[2] References to the Code of Federal Regulations will be abbreviated as "CFR" throughout this document

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	subgrantees ***Note:*** Forms can be obtained from the CFR website: http://ecfr.gpoAccess.gov	appropriate, a "Disclosure of Lobbying Activities" • Ensure that subgrantee staff are familiar and in compliance with prohibitions on lobbying with federal funds	orientation information on regulations that forbid lobbying with federal funds	Hopson Letter 2/3/09
9. No use of Part B funds for foreign travel	• Implementation of actions specified in B.1. above • Review program plans, budgets and budget narratives for foreign travel	• 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.	PHS ACT 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 other funding sources 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 records 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 subgrantee agreement or through another mechanism that subgrantees maximize and monitor third party reimbursements • Requirement that subgrantees document in client record how each client has been screened for and enrolled in eligible programs • Monitoring to determine that Ryan White is serving as the payer of last resort, including review of client records 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 payer 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 records • Carry out internal reviews of files and billing system to ensure that Ryan White resources are used only when a third party payer is not available • Establish and maintain medical practice management systems for billing	PHS ACT 2617 (b) (iii) Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
2. Assure billing and collection from third party payers, including Medicare and Medicaid, so that payer of last resort requirements are met	• Inclusion in subgrantee agreements of language that requires billing and collection of third party funds • Review of the following subgrantee systems and procedures: ○ Billing and collection policies and procedures ○ Electronic or manual system to bill third party payers ○ Accounts receivable system for tracking charges and payments for third party payers	• Include provisions in subgrantee 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	Establish and consistently implement in medical offices and pharmacies: • Billing and collection policies and procedures • Billing and collection process and/or electronic system • Documentation of accounts receivable	Funding 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
4. Ensure billing, tracking, and reporting of program income by grantee and	Review of subgrantee billing, tracking, and reporting of program income, Review of	• Monitor subgrantees to ensure appropriate billing and tracking of	Bill, track, and report to the grantee all program income billed and obtained	45 CFR Part 74.14 45 CFR Part C

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
subgrantees that provide reimbursable expenses	program income reported by the grantee in the FFR and annual reports	program income, Require subgrantee reporting of program income		92.25 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 program, except in ADAP.	• 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
Section D: **Imposition & Assessment of Client Charges**				
1. Ensure grantee and	Review of subgrantee policies	Review subgrantee:	Establish, document, and	PHS ACT 2617

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
subgrantee policies and procedures specify a publicly posted schedule charges (e.g. sliding fee scale) 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	and procedures, to determine: • Existence of a provider policy for a schedule of charges. • Publicly posted schedule of charges based on current Federal Poverty Level (FPL) including cap on charges • Client eligibility for imposition of charges based on schedule. • Track client charges made and payments received • How accounting system are used for tracking charges, payments, and adjustments	• Policy for a schedule of charges • Client eligibility determination procedures for imposition of charges • Description of accounting system used to for tracking patient charges, payments, and adjustments If providing direct services, meet same requirements as subgrantees	have available for review: • Policy for a schedule Current schedule of charges • Client eligibility determination in client records • Fees charged by the provider and payments made to that provider by client • Process for obtaining and documenting client charges and payments through an accounting system manual or electronic	(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) ***Note:*** This standard applies to all services, including ADAP	Review of provider policy for schedule of charges to ensure that clients with incomes below 100% of the FPL are not charged for services, including ADAP services	• Review subgrantee eligibility determination procedures and ensure that clients with incomes below 100% of the FPL are not to be charged for services • Review client records 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	Document that: • Policy for schedule of charges does not allow clients below 100% of FPL to be charged for services • Personnel are aware of and consistently following the policy and schedule of charges • Policy for schedule of charges must be publically posted	PHS ACT 2617 (c) (1) (A)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		charged for services		
3. Charges to clients with incomes greater than 100% of poverty are determined by the schedule of charges. Annual limitation on amounts of charge (i.e. caps on charges) for Ryan White services (including ADAP) are 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 300% of FPL	• Review of the schedule of charges and cap on charges policy. • Review of accounting system for tracking client charges and payments • Review of charges and payments to ensure that charges are discontinued once the client has reached his/her annual cap on charges	• Review of the schedule of charges and cap on charges policy • Review accounting system and records of charges and payments to ensure compliance with caps on charges • Review client eligibility determination application to ensure consistency with policies and federal requirements	Establish and maintain a schedule of charges policy that includes a cap on charges and the following: • Responsibility for client eligibility determination 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 • Personnel are aware of and consistently following the policy and schedule of charges and cap on charges	PHS ACT 2617 (c)(1)(C-E) PHS ACT 2617 (c)(3)
Section E: **Financial Management**				
1. Compliance by grantee and subgrantees with all the established standards in	• Review of grantee and subgrantee accounting systems to verify that they	• Ensure access to and review: o Subgrantee	Provide grantee personnel access to: • Accounting systems,	45 CFR 77 45 CFR 74 45 CFR 78 45 CFR 92

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 • Rebates • 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, 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	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: ○ Payment of subgrantee contractor invoices ○ Allocation of expenses of subgrantees among multiple funding sources • Review of grantee and subgrantee: ○ Financial operations policies and procedures ○ Purchasing and procurement policies and procedures ○ 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	accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports ○ All financial policies and procedures, including billing and collection policies and purchasing and procurement policies ○ 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 subgrantee 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	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 79 45 CFR 80 45 CFR 82

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		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
3. Line-item grantee and subgrantee budgets that include at least five category columns: • Administrative • Planning and Evaluation • Clinical Quality Management (CQM) • HIV Services	• 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	• 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	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
• ADAP • MAI, if applicable	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	staff ○ Contractual Services - personnel or services contracted to outside providers, for activities not done in-house ○ Administration- all funds allocated to the following grant activities: grantee administration, planning and evaluation, and quality management ○ ADAP - all funds allocated to the following grant activities: AIDS Drug Assistance Program ○ Consortia - all funds allocated to consortia and emerging communities ○ Direct Services- all funds allocated to the following grant activities: state direct services, home and community-based care, MAI, and health insurance continuation		

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		• 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 subgrantee 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) ***Note:*** A significant modification occurs under a grant where the federal share exceeds $100,000, when cumulative transfers among direct cost	• 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 agreements specification of which	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
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)		budget revisions require approval, and provide written instructions on the budget revision process		
5. Provider subgrantee agreements, statements of work, MOU/MOA and other contracts that meet all applicable federal and local statutes and regulations governing subgrantee/contract award and performance Major areas for compliance: a. Follow state law and procedures when awarding	Development and review of Part B subgrantee agreements and contracts to ensure compliance with local and federal requirements	• Prepare subgrantee agreements/contracts that meet both federal and local contracting requirements and provide specific clauses as stated in the Standard • Maintain file documentation of Part B subgrantee agreements/contracts and Award Letters	• Establish policies and procedures to ensure compliance with subgrantee provisions • Document and report on compliance as specified by the grantee	45 CFR 74.2 45 CFR 92.37 2 CFR 215.23

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
and administering subgrants (whether on a cost reimbursement or fixed amount basis) b. Ensure that every subgrantee includes any clauses required by Federal statute and executive orders and their implementing regulations c. Ensure that subgrantee 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 substantially conform to the standards of timing and amount that apply to cash advances by federal agencies		• Revise subgrantee agreements/contracts annually to reflect any changes in federal requirements Monitor compliance with subgrantee provisions		
Section F: **Property Standards**				
1. Grantee and subgrantee tracking of and reporting on tangible nonexpendable personal property, including exempt property, purchased directly with	Review to determine that the grantee and each subgrantee has a current, complete, and accurate: • Inventory list of capital assets purchased with	• Develop and maintain a current, complete, and accurate asset inventory list and depreciation schedule • Ensure that each	• Develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment	45 CFR 74.34 2 CFR 215.34 45 CFR 92.32 9(a)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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)	Ryan White funds • Depreciation schedule that can be used to determine when federal reversionary interest has expired	subgrantee maintains a current, complete, and accurate asset inventory list and depreciation schedule, and that they identify assets purchased with Ryan White funds	by funding source • Make the list and schedule available to the grantee upon request	
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 appropriately registered • Review depreciation schedule for capital assets for completeness and accuracy	• 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.
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 reversionary interest	• Implementation of actions specified in F.1 above • Review to ensure grantee and subgrantee policies that: o Acknowledge the reversionary interest of the federal government over property purchased with federal funds o Establish that such property may not be encumbered or disposed	• 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	• 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	45 CFR 74.32 45 CFR 92.31 2 CFR 215.32

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	of without HRSA/HAB approval	• 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	for grantee review	
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 need for the property, it will be declared excess and reported to the General Services Administration	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
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	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

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
on non-federally sponsored activities or sell them • Compensate the federal government for its share contributed to purchase of supplies				
Section G: **Cost Principles**				
1. Payments made to 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 Circular the Code of Federal Regulation	Review grantee and subgrantee budgets and expenditure reports to determine whether use of funds is consistent with OMB and CFR cost requirements	• Ensure that grantee expenses conform to federal cost principles for cost-reimbursable grants. • Ensure grantee and subgrantee staff familiarity with OMB Circular 122 or Code of Federal Regulation (2 CFR 230) requirements • Ensure that grantee and subgrantee budgets and expenditures conform to OMB Circulars and CFR requirements • Include in subgrantee agreements a provision requiring compliance with OMB cost principles	• Ensure that budgets and expenses conform to federal cost principles • Ensure fiscal staff familiarity with applicable federal regulations	2 CFR 230 or OMB Circular A-122 2 CFR Appendix A 225 D 1 (51912)
2. Payments made for services and drugs for	• Review of subgrantee budgets and expenditure	• Submit reasonable and accurate budgets and	• Make available to the grantee a very detailed	2 CFR 230

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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	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	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 • Review and keep on file he following documentation for each subgrantee: o Current budget o Unit cost agreement and calculation. • Fiscal and productivity reports	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	OMB Circular 122 Appendix A to Part 230 2 CFR A II 225 Appendix A C (2) 2 CFR 220 Appendix A (C) 3 or OMB Circular A-21
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	• 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 • Test to determine whether subgrantee costs for services as charged to the program	• Have in place policies and procedures to determine allowable and reasonable costs • Have in reasonable methodologies for allocating costs among different funding sources	2 CFR 230 OMB Circular A-122

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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		are reasonable and allowable	and Ryan White categories • Make available policies, procedures, and calculations to the grantee on request	
4. Calculation of unit costs 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	• Review unit cost methodology for subgrantee and provider services. • Review budgets to calculate allowable administrative and program costs for each service.	Include in subgrantee 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.	Have in place systems that can provide expenses and client utilization data in sufficient detail to determine reasonableness of unit costs	*Determining the Unit Cost of Services* (HRSA publication)

[2] GAAP = Generally Accepted Accounting Principles

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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%, 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)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
6. Requirement that States and Territories must secure the best price available for all products on their ADAP formularies. ***Note**:* Failure to participate in cost-saving programs may result in a negative audit finding and cost disallowance	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 pricing or prime vendor program.	• Ensure that drug acquisition practices are compliant with federal requirements regarding cost-effectiveness and reasonableness • 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	• Participate in 340 B Pricing Program • Use purchasing policies and procedures that meet federal requirements	CFR 42. Part 50 (e) Doug Morgan Letter 4/10/06 Part B Manual 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 rebate 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	• 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	N/A	PHS ACT 2622 (d)(1) PHS ACT 2616 (9)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	reported unobligated balance.	provision		
8. Cost of health insurance or plans to be purchased or maintained not to exceed the cost of providing the drugs through ADAP	• Verification that the grantee has conducted a cost analysis that show 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	Document a cost analysis demonstrating that the cost of health insurance or plans is 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	• Establish policies and procedures that ensure contract requirements are met • Provide detailed expense reports to enable the grantee document that costs are at or below the cost of providing the drugs through ADAP	PHS ACT 2616 (f)(1-2) HAB Policy Notice 99-01
Section H: **Auditing Requirements**				

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
1. Recipients and sub-recipients of Ryan White funds that are institutions of higher education or other non-profit organizations (including hospitals) are 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 expending more than $500,000 per year in federal grants	Review requirements for subgrantee audits Review most recent audit (which may be an A-133 audit) to assure it includes: ○ List of federal grantees to ensure that the Ryan White grant is included ○ 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	• Include in subgrantee agreement a requirement for a timely annual audit and associated management letter (an A-133 audit if federal grants total more than $500,000) • 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	• 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 management letter to the grantee • Prepare and provide auditor with income and expense reports that include payer of last resort verification	CFR 74.26 2 CFR 215.26 OMB Circular A-133 Deborah Parham-Hopson Letter 09/20/12 http://hab.hrsa.gov/manageyourgrant/files/subgrantaudit.pdf
2. Based on criteria established by the grantee, Ryan White subgrantees or subrecipients that are small programs (i.e. receive less than $500,000 per year in federal grants) may be subject to audit as a major program (i.e. a program	3. Review requirements for "small program" subgrantee audits 4. Review most recent audit (which may be an A-133 audit) to determine if it includes: ○ List of federal grantees and determine if the Ryan White grant is	• Include a statement in agreements with small program subgrantees (i.e. those receiving less than $500,000 in federal grants) that they may be subject to an annual A-133 audit. • Establish criteria for determining when a	• Prepare and provide auditor with financial and other documents required to conduct a major program audit (e.g. income and expense reports that include payer of last resort verification, timesheets, general ledger, etc.)	Deborah Parham-Hopson Letter 09/20/12 http://hab.hrsa.gov/manageyourgrant/files/subgrantaudit.pdf

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
that receives more than $500,000 in aggregate federal funding) pursuant to OMB Circular A-133, Section .215 c).	included ○ Programmatic income and expense reports to assess if the Ryan White grant is included • Review audit management letter • Review all programmatic income and expense reports for payer of last resort verification by auditor	small program subgrantee will be subject to a major program audit (i.e. an A-133 audit). • When requiring an audit as a major program, give the auditee (i.e. the subgrantee) 180 days' notice before their fiscal year end • Select an auditor based on grantee policies and procedures for auditor selection • Pay for the audit with grant funds from the grantee's administrative budget • Maintain file documentation of subgrantee audits and management letters • Request a management letter from the auditor and review to determine if there are any material weaknesses. • Review audit for income and expense reports testing of payer of last resort verification	• Comply with contract audit requirements on a timely basis	
5. Selection of auditor to be based on Audit Committee	• Review of subgrantee financial policies and	• Ensure financial policies and procedures	• Have in place financial policies and procedures	CFR 74.26 2 CFR 215.26

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
for Board of Directors (if nonprofit) policy and process	procedures related to audits and selection of an auditor	in place for auditor selection • Ensure that subgrantees have policies and procedures in place to select an auditor	that guide selection of an auditor • Make the policies and procedures available to grantee on request	45 CFR 92.26 OMB Circular A-133
6. 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 Circular A-133
7. A-133 audits to include statements of conformance with financial requirements and other federal expectations	Review of statements of internal controls and federal compliance in A-133 audits	Annually review statements of internal controls and federal compliance in subgrantee A-133 audits to determine compliance with federal expectations	• Comply with contract audit requirements on a timely basis • Provide audit to grantee on a timely basis	OMB Circular A-133
8. 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 Circular A-133
9. State collection of audits	• Review to ensure that A-	• Have documented	• Comply with audit	PHS ACT 2617

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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	133 or other audits (where A-133 audits are not required) have been completed, collected, and submitted to HHS every two years	evidence of grantee and subgrantees A-133 and other audits	requirements	(b)(4)(E)
Section I: **Matching or Cost-Sharing Funds**				
1. Grantees required to report to HRSA/HAB information regarding the portion of the 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	• Review grantee annual comprehen sive budget • Review all grantee in-kind and other contributions to Ryan White program • Grantee documentation of other contributed services or expenses	• Report to HRSA/HAB on the non-federal funds or in-kind resources the State or Territory is allocating to the program • Ensure that the non-federal contributio n meets all the requiremen ts stated in the Standard in I.1	Where subgrantee on behalf of the grantee provides matching or cost sharing funds, follow the same verification process as the grantee	45 CFR 92.24 2 CFR 215.27 45 CFR 74.23 PHS ACT 2617(d)(1)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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 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				
1. Non-federal contributions	• Review of Part B	• Pr	• Where subgrantee	PHS ACT

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
by States and Territories that are equal to $1 for each $4 of federal ADAP supplemental funds and $1 for each $2 awarded under ADAP, unless a waiver is obtained	to determine that matching requirement for ADAP funds has been met • Review of grantee documentation of reported matching contributions	the information and documentation of required matching contribution. • Assure that matching contribution meets	behalf of the grantee provides matching or cost sharing funds, follow the same verification process as the grantee	2618(a)(2)(F)(ii)
2. 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	• 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	PHS ACT 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-related core medical	• Review core medical services and support service budget elements that document the contributions of the State or Territory • Review tracking/ accounting system that	Submit the following MOE information to HRSA/HAB annually: • A list of core medical and support	N/A	PHS ACT 2617 (b)(7)(E) Funding Opportunity Announcement Part B Manual

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
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	contribution to core medical services and supportive services • Review of grantee budget for State or Territory contributions • Review of actual tracking/accoun ting 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		
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 supplement federal support of HIV Core Medical services	Prepare and submit to HRSA/HAB the suggested template 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	PHS ACT 2617(d)(2)(A) Funding Opportunity Announcemen t Part B Manual
Section K: **Fiscal Procedures**				
1. Grantee and subgrantee policies and procedures in place for handling revenues from the Ryan White grant, including program income and federally generated	• Review policies and procedures related to the handling of cash or Ryan White grantee or subgrantee	• Establish policies and procedures for handling Ryan White revenue • Prepare a detailed chart of accounts and general ledger that	• Establish policies and procedures for handling Ryan White revenue including program income • Prepare a detailed	OMB Circular A-133 Deborah Parham-Hopson Letter, 11/16/2012

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
rebates	to verify that cash and grant revenue is being recorded appropriately	the tracking of Part B revenue • Monitor policies and handling of Ryan White revenues by subgrantees	of accounts and general ledger that provide for the tracking of Part B revenue • Make the policies and process	
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	• Provide expense documentation with every payment management system draw-down or reconciled PMS request to expenses on a monthly basis • Establish subgrantee	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 grantees and subgrantees in the use of Ryan White funds	Review of subgrantee agreements to ensure that language is included that guarantees access to records and documents as required to oversee the performance of the Ryan White subgrantee	Include a provision in subgrantee agreements that guarantees grantee • access to subgrantee records and documents for program and fiscal monitoring	Have in place policies and procedures that allow the grantee as funding agency prompt and full access financial, program, and management records and documents as needed for program and fiscal monitoring and oversight	45CFR 74.61 (b)4(e) 45CFR 92.41

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		ensure HRSA/HAB similar access to grantee records and documents		
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	• Maintain file documentation of payroll records and accounts payable, and hard-copy expenditures data • Include in subgrantee agreements conditions that	• 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 failed to comply with grant award conditions	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)
6. Awarding agency to make payment within 30 days after receipt of a billing, unless the billing is	• Review of grantee's payable records • Review of subgrantee invoices, submission	• Establish and implement policies and procedures that allow for partial	• Submit invoices on time monthly, with complete documentation	2 CFR 215.22 (e)(4) Part C 45 CFR 92.21 45CFR 74.22

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
improperly presented or lacks documentation	and bank deposits of Part B payments • Review of grantee policies on how to avoid payment delays of more than 30 days to subgrantees	invoices • Review reimbursement to subgrantees to determine whether it routinely occurs within 30 days of receipt of Invoice, and document	documenting reimbursement period, including monthly bank reconciliation reports and receivables aging report	
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	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	Fair Labor Standards Act (29 CFR 516) 2 CFR 230 Appendix B C.2 (d) 3 or OMB Circular A-122
8. Applicants for Ryan White Part B funds will present a staffing plan and provide a justification for the plan that	• Review grantee Staffing Plan • Review of	As part of application, provide: • Staffing Plan • Budget and budget	N/A	Funding Opportunity Announcement

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
includes education and experience qualifications and rationale for the amount of time being requested for each staff position	related budget justification, including staff positions, education and experience qualifications, and rationale for the amount of time requested for each staff person	justification, including staff positions, education and experience qualifications, and rationale for the amount of time requested for each staff person		
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*	• 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: ○ Program and fiscal staff resumes and job descriptions ○ Staffing Plan and grantee budget and budget justification ○ Grantee organizational chart • Require and review similar information for subgrantee applicants	• Prepare the following: ○ Program and fiscal staff resumes and job descriptions ○ Staffing Plan and grantee budget and budget justification ○ Subgrantee organizational chart • Provide information to the grantee upon request	Funding Opportunity Announcement
10. States and territories to submit an estimation of carryover funds 60 days prior to the end of the grant	• Review of carryover request • Review of grantee accounting reports that	• Prepare accounting reports that document	N/A	Dr. Parham-Hopson Letter 12/5/07

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
period – by January 31 of every calendar year	included in carryover request	request • Prepare and submit estimated unobligated balances and estimated carryover request 60 days prior to end of grant year. **NOTE:** No requests will be		HAB Policy Notice 12-02
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 ***NOTE:*** States and territories to submit an estimation of unobligated balance 60 days prior to the end of the grant period – by January 31 of every calendar 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	• 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	• Report monthly expenditures to date to the grantee • Inform the grantee of variances in expenditures	PHS ACT 2622 (c)(4)(A)(i) HAB Policy Notice 12-02

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		methodology and implement it (in coordination with Consortia if present) • Prepare and submit estimated unobligated balances and estimated carryover request 60 days prior to end of grant year.		
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)	• 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	• Provide timely reporting of unspent funds, position vacancies, etc. to the grantee • Establish and implement a process for tracking unspent Part B funds and providing accurate and timely reporting to the grantee	PHS ACT 2620 (a)(2) HAB Policy Notice 12-02

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
		assure its reconciliation with the State or Territory's Formula, Supplemental, and carryover expenditures		
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 applied: • Future year award is offset by the amount of the unobligated balance • Future year award is reduced by amount of unobligated balance less any approved carry over • The grantee is not	• Review State or Territory compliance with any cancellation of unobligated funds • Review grantee and subgrantee budgets and implementation of plans in order to maintain service levels during a penalty year	• 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	PHS ACT 2622 (b) (1-2) HAB Policy Notice 10-01
Section M: Tracking and Reporting Use of Rebates				
1. Ensure collected rebates are applied to the Part B Program with a priority, but not a requirement that the	• Review of grantee and subgrantee systems for tracking and reporting rebates generated by Ryan	Track rebate funds to ensure they are placed back into the Part B Program		PHS ACT 2616(g) 45 CFR 92.21(f)(2)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
rebates be placed back into ADAP	White-funded services Review of uses of rebates, including review of expenditure reports or other documentation			Dr. Parham-Hopson Letter and FAQs 11/16/2012
2. Ensure grantee spends their rebate funds prior to drawing down grant funds from the Payment Management System ***Note:*** If a grantee is unable to obligate grant funds because rebate funds must be obligated first, the grantee may request that the amount of the UOB be reduced by the amount of obligated rebate funds (as recorded in the FFR) and that such amount be carried forward. Rebates shall be recorded in the Remarks Section of the FFR using the following format. "STATE NAME has an unobligated balance due to rebate funds and is requesting to reduce the unobligated grant fund balance of XXX by the amount of XXXX in rebate funds. • Rebate funds received $ • Rebate funds expended $ Total $	• Review systems to ensure rebate funds are spent prior to drawing down funds from Payment Management System • Ensure rebate funds are spent in the grant year in which they are received	Report total amount of rebate funds spent and report on line 12 of the Federal Financial Report (FFR) ***Note:*** Rebate funds should never be recorded as an unobligated balance (UOB) on an FFR. •		PHS ACT 2616(g) 45 CFR 92.21(f)(2) Dr. Parham-Hopson Letter 11/16/2012 NMS FAQs 2013 HAB Policy 12-02

Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program

Policy Clarification Notice (PCN) #13-04 (Revised 9/13/2013)
Relates to HAB Policy #13-01, #13-02, #13-05

Scope of Coverage: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy notice clarifies HRSA policy regarding the Ryan White HIV/AIDS Program (RWHAP) and its relationship to clients' eligibility and enrollment in private health insurance.

Background

By statute, RWHAP funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by another payment source.[1] This means grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer- sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

The RWHAP will continue to be the payer of last resort and will continue to provide those RWHAP services not covered, or partially covered, by public or private health insurance plans.

This PCN clarifies how the RWHAP payer of last resort requirement applies to clients eligible for private health insurance coverage. Grantees and subgrantees should also refer to *Policy Clarification Notice #13-01: Clarifications Regarding Medicaid- Eligible Clients and Coverage of Services by Ryan White HIV/AIDS Program* (http://hab.hrsa.gov/manageyourgrant/pinspals/1301pcnmedicaideligible.pdf) to understand the RWHAP expectations and requirements for individuals who may be eligible for Medicaid.

[1] *See* Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

Instructions

Client Eligibility and Enrollment into Private Health Insurance

For policy years beginning on or after January 1, 2014, insurers will be prohibited from denying coverage because of a pre-existing condition, including HIV/AIDS, and many RWHAP clients may become newly eligible for private health insurance.

Because the RWHAP is the payer of last resort, RWHAP grantees and subgrantees must make every reasonable effort to ensure all uninsured RWHAP clients enroll in any health coverage options for which they may be eligible. This means that grantees and subgrantees are expected to ensure that clients who are determined by the state Medicaid agency and/or the Marketplace to be ineligible for public programs (Medicaid, CHIP, Medicare, etc.) are also assessed for eligibility for private health insurance (e.g., employer-sponsored health plans and health plans offered through the Marketplace).

Under existing guidance, grantees and subgrantees must make every reasonable effort to ensure eligible uninsured RWHAP clients expeditiously enroll in private health insurance plans whenever possible, and inform clients about any consequences for not enrolling. Specifically, RWHAP clients should be informed that under the Affordable Care Act, starting in 2014, if someone can afford it but doesn't have health insurance coverage,[2] they may have to pay a fee.[3] Some individuals may be exempt from the Affordable Care Act's requirement to enroll in health coverage. In these circumstances, the Health Insurance Marketplace or the Internal Revenue Service (IRS) will provide individuals with certificates of exemption if they meet certain criteria.[4] RWHAP clients who obtain a certificate of exemption may continue to receive services through the RWHAP. Under no

[2] To meet the individual responsibility requirement under the Affordable Care Act individuals will need coverage such as individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE or certain other coverage. *See* HealthCare.gov, What if someone doesn't have health insurance?, https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014. *See also* Internal Revenue Service, Questions and Answers on the Individual Shared Responsibility payment Question #5, http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

[3] Starting January 1, 2014, if someone doesn't have a health plan that qualifies as minimum essential coverage, he or she may have to pay a fee that increases every year: from 1% of income (or $95 per adult, whichever is higher) in 2014 to 2.5% of income (or $695 per adult) in 2016. The fee for children is half the adult amount. The fee is paid on the 2014 federal income tax form, which is completed in 2015. *See* HealthCare.gov, What if someone doesn't have health insurance?, https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014.

[4] Individuals may be exempt from paying the fee for failing to enroll in minimum essential coverage if they (1) are members of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits and adhere to the tenets of that sect; (2) are members of a recognized health care sharing ministry; (3) are members of a federally recognized Indian tribe; (4) have household income below the minimum threshold for filing a tax return; (5) only went without the required coverage for a short coverage gap of less than three consecutive months during the year; (6) were certified by a Health Insurance Marketplace as having suffered a hardship that makes them unable to obtain coverage; (7) cannot afford coverage because the minimum amount the individual must pay for premiums is more than eight percent of the individual's household income; (8) are in jail, prison or similar penal institution or correctional facility after the disposition of charges; and (9) are not U.S. citizens, U.S. nationals, or aliens lawfully present in the U.S. *See* IRS, Questions on Individual Shared Responsibility Provision Question #6, http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

circumstances may RWHAP funds be used to pay the fee for a client's failure to enroll in minimum essential coverage.

Grantees should be aware that clients can only enroll in a private health plan during an open enrollment period,[5] unless they qualify for a special enrollment period based on a qualifying life event, such as moving to a new state, eligibility changes for premium tax credits and/or cost-sharing reductions, or loss of employer-sponsored coverage.[6] If a client misses the open enrollment period and cannot enroll, it is expected that the grantee will make every reasonable effort to ensure the client enrolls into a private health plan upon the next open enrollment period. If a client qualifies for a special enrollment period, it is expected that the grantee will make every effort to ensure the client enrolls in a private health plan before the special enrollment period closes.

HAB will require grantees to maintain policies regarding the required process for the pursuit of enrollment for all clients, to document the steps during their pursuit of enrollment for all clients, and establish stronger monitoring and enforcement of subgrantee processes to ensure that clients are enrolled in coverage options for which they qualify. If after extensive documented efforts on the part of the grantee, the client remains unenrolled in health care coverage, the client may continue to receive services through the RWHAP.

It is also expected that RWHAP grantees collect and maintain documentation verifying client eligibility for other health coverage or a certificate of exemption from the Marketplace or IRS. *See Policy Clarification Notice #13-02: Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirement* (http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf).

Effective Date of Coverage

Individuals enrolling in a new private health plan may experience a gap in coverage between submission of their enrollment application and the date on which the health plan will begin to pay for services received by the individual. Generally, payments for items or services will not be made, or cannot reasonably be expected to be made, by the health plan until the effective date of coverage begins. As such, RWHAP funds may be used to pay for items or services up until a client's effective date of coverage if those items or services are not covered by any other funding source. RWHAP funds may not be used to pay for items or services received on or after the effective date of coverage if they are covered by the client's insurance plan. In the event that RWHAP-funded services were provided on or after the effective date of coverage, grantees and subgrantees providing those services must

[5] The initial open enrollment period for the individual Marketplaces will be from October 1, 2013, through March 31, 2014. After the initial open enrollment period, annual open enrollment will occur from October 15 to December 7 every year. *See* 45 CFR 155.410.
[6] *See* 45 CFR 155.420(d) for more examples of events that may trigger a special enrollment period.

make every reasonable effort to collect payment from the private insurance plan for those RWHAP-funded services.

Coverage of Services by Ryan White HIV/AIDS Program for Clients Enrolled in Private Health Insurance

Once a client is enrolled in a private health plan, RWHAP funds may only be used to pay for any Ryan White HIV/AIDS Program services not covered or partially covered by the client's private health plan.

In addition, RWHAP grantees are strongly encouraged to use RWHAP funds to help clients purchase and maintain health insurance coverage, if cost-effective and in accordance with RWHAP policy. *See Policy Clarification Notice #13-05 Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance* (http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf).

Health Plan Provider Networks

RWHAP funds generally may not be used to pay for services that the client receives from a provider that does not belong to the client's health plan's network, unless the client is receiving services that could not have been obtained from an in-network provider.

Some health plans may have "tiered" networks that require individuals to pay more to see some providers. As such, providers in any covered tier are not considered "out-of-network." Grantees and subgrantees are not prohibited from using RWHAP funds to pay for out-of-pocket expenses when the client receives services from a provider in a higher-cost tier, including client out-of-pocket expenses. However, the effect of such payments on available resources should be considered by grantees and subgrantees prior to making such allocations.

Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost- Sharing Assistance for Private Health Insurance *Policy Clarification Notice (PCN)* #13-05

(Revised 6/6/2014)

Relates to HAB Policy #'s 10-02 and 7-05

Scope of Coverage: Ryan White Parts A, B, C, D, and Part F where funding supports direct care and treatment services.

Purpose of PCN

This policy clarification notice reiterates HRSA policy regarding the use of Ryan White HIV/AIDS Program (RWHAP) for premium and cost-sharing assistance for the purchase and maintenance of private health insurance coverage. It also provides RWHAP grantees and subgrantees with additional guidance on using RWHAP funds for premium and cost-sharing assistance.

Background

Under the Affordable Care Act, beginning January 1, 2014, options for health care coverage for PLWH have been expanded through new private insurance coverage options available through Health Insurance Marketplaces (also referred to as Exchanges) and the expansion of Medicaid in States that choose to expand. Health insurers also will be prohibited from denying coverage because of a pre-existing condition, including HIV/AIDS. An overview of these health care coverage options may be reviewed at http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf.

By statute, RWHAP funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by another payment source.[1] This means grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer- sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

Grantees and subgrantees must also assure that individual clients are enrolled in health care coverage whenever possible or applicable, and informed about the consequences for not enrolling.[2]

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[1] *See* Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1), and 2671(i) of the Public Health Service Act.

[2] Under the Affordable Care Act, starting in 2014, if someone can afford it but doesn't have health insurance coverage in 2014, they may have to pay a fee. *See* HealthCare.gov, What if someone doesn't have health insurance?, https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014. Under no circumstances may RWHAP funds be used to pay this fee for a client's failure to enroll in minimum essential coverage.

As Affordable Care Act implementation continues, clients will become eligible for and enroll in qualified health plans offered in the Marketplace. The RWHAP will continue to be the payer of last resort and will continue to provide those RWHAP services not covered, or partially covered, by public or private health insurance plans. RWHAP grantees and subgrantees should consider helping individual clients pay for premiums and/or cost-sharing, if cost-effective.

Requirements and Expectations for RWHAP Grantees and Subgrantees

By statute, RWHAP funds awarded under Parts A, B, and C may be used to support a Health Insurance Premium and Cost-Sharing Assistance Program, a core medical service, for eligible low-income HIV positive clients.[3] Consistent with the RWHAP statute, "low-income" is to be defined by the EMA/TGA, State, or Part C grantee. RWHAP Part D grantees may also use funds to purchase and maintain health insurance, if cost-effective.

RWHAP funds may be used to cover the cost of private health insurance premiums, deductibles, and co-payments to assist eligible low-income clients in maintaining health insurance or receiving medical benefits under a health insurance or benefits program, including high risk pools. However, RWHAP funds may not be used to pay for any administrative costs outside of the premium payment of the health plans or risk pools.

If resources are available, Part A planning bodies and Ryan White Part B, C and D grantees may choose to prioritize and allocate funding to health insurance premium and cost-sharing assistance for low-income individuals in accordance with Section 2615 of the Public Health Service Act. The grantee must determine how to operationalize the health insurance premium and cost-sharing assistance program, including the methodology used by the grantee to: (1) assure they are buying health insurance that at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services; and (2) assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate primary care services. The grantee may consider providing the resource allocation to the Part B/AIDS Drug Assistance Program (ADAP) which currently operates the health insurance continuation programs in some States and, therefore, has the infrastructure to verify coverage status and process payments to health plans for premiums, co-payments and deductibles, and to pharmacies for medication co-payments and deductibles.

[3] *See* Section 2604(c)(3)(F), Section 2612(c)(3)(F), and Section 2651(c)(3)(F) of the Public Health Service Act.

Requirements and Expectations Specific to Part B AIDS Drug Assistance Program (ADAP)

ADAP funds may be used to cover costs associated with a health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain health insurance coverage. In order to use Part B ADAP funds to purchase health insurance, State ADAPs must be able to document for HRSA/HAB the methodology used by the State to: (1) assure they are buying health insurance that at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS Clinical Guidelines for the Treatment of HIV/AIDS as well as appropriate primary care services; and (2) assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications.

Grantees should refer to *HAB Policy Notice 07-05, "The Use of Ryan White HIV/AIDS Program Part B ADAP Funds to Purchase Health Insurance"* (http://hab.hrsa.gov/manageyourgrant/files/partbadapfundspn0705.pdf).

RWHAP Premium and Cost-Sharing Assistance and the Affordable Care Act

The Affordable Care Act increases access to affordable health insurance by establishing a Health Insurance Marketplace in every state where individuals may purchase private health insurance. Many individuals may be eligible for premium tax credits and cost-sharing reductions to help pay for private health insurance offered in the Marketplace. Consequently, RWHAP grantees and subgrantees should take into consideration other sources of premium and cost-sharing assistance when determining how to operationalize a premium and cost-sharing assistance program, as discussed below.

Use of RWHAP Funds for Clients Eligible for Advance Premium Tax Credits

Many RWHAP clients with incomes between 100-400% of the federal poverty level (FPL) without access to certain types of minimum essential coverage[4] may be eligible for premium tax credits to offset the cost of purchasing a qualified health plan[5] through their state's Marketplace.[6] The amount of the premium tax credit is

[4] "Minimum essential coverage" refers to the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes employer-sponsored coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage as defined in Internal Revenue Code Section 5000(a).

[5] A qualified health plan is a health insurance plan that is certified by a Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold. *See* http://www.healthcare.gov/glossary/q/qhp.html.

based on the individual's income and the cost of the second-lowest cost silver plan[7] available to them offered in the Marketplace. Once an individual enrolls in a qualified health plan in the Marketplace, the individual can control how much of the projected tax credit is used to help pay the monthly health plan premiums. The tax credit is sent directly to the insurance company and applied to the individual's premium, so the individual pays less out of his/her own pocket.

Grantees and subgrantees may use RWHAP funds to pay for any remaining premium amount owed to the health insurance company that is not already covered by the RWHAP client's premium tax credits. Grantees and subgrantees should take the following into consideration when operationalizing their health insurance premium and cost-sharing assistance program:

- State-based Marketplaces have flexibility to implement a process for premium payment aggregation. Grantees and subgrantees should work with health insurance issuers and/or the State-based Marketplace to establish a coordinated process that facilitates premium payments by the RWHAP for individual clients.
- In states with a Federally-Facilitated Marketplace, grantees and subgrantees will need to work directly with health insurance issuers to facilitate premium payments by the RWHAP for individual clients.

Use of RWHAP Funds for Clients Eligible for Cost-Sharing Reductions

Many RWHAP clients with incomes between 100-250% FPL who receive the advance premium tax credits may also be eligible for additional cost-sharing reductions to lower their out-of-pocket expenses, such as co-payments and deductibles. In order to receive cost-sharing reductions, individuals must receive a premium tax credit and enroll in a silver level plan offered in the Marketplace.

As discussed above, RWHAP funds may only be used to purchase and maintain health insurance that is cost-effective. In determining which qualified health plan in the Marketplace is the most cost-effective for clients eligible for cost-sharing reductions, grantees and subgrantees are encouraged to analyze the formulary adequacy and other essential medical benefits, the cost of the premium, and the effect of any cost-sharing reductions on the overall cost of the qualified health plan. RWHAP grantees and subgrantees should inform clients regarding these analyses to assist RWHAP clients in enrollment decisions.

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[6] Legal residents with incomes below 100% FPL who have been in the United States for less than five years may also be eligible for advance premium tax credits provided they are not eligible for Medicaid or other minimum essential coverage.

[7] There are four types of coverage that will be offered in each Marketplace: bronze, silver, gold, and platinum. A silver level qualified health plan (QHP) is a health plan offered in the Marketplace with an actuarial value (AV) of 70 percent. A bronze level QHP has an AV of 60 percent, a gold level QHP has an AV of 80 percent, and a platinum QHP has an AV of 90 percent.

Even if an individual is eligible for cost-sharing reductions, he/she may still incur some cost-sharing in his/her health plan. RWHAP funds may be used to cover any remaining costs of co-payments and deductibles if the grantee has established a Health Insurance Premium and Cost-Sharing Assistance Program and be able to document for HRSA/HAB the methodology used to determine if the program is cost-effective.

Use of RWHAP Funds for Clients Not Eligible for Premium Tax Credits and Cost-Sharing Reductions in a Health Insurance Marketplace

Grantees and subgrantees should consider that some individuals are ineligible for premium tax credits and cost-sharing reductions:

- Clients under 100% FPL in states that do not implement Medicaid expansion;[8]
- Clients with incomes above 400% FPL;
- Clients who have minimum essential coverage other than individual market coverage (*e.g.,* Medicaid, CHIP, TRICARE, employer-sponsored coverage, and certain other coverage defined in Internal Revenue Code Section 5000(a)) available to them, but choose to purchase in the Marketplace; and
- Clients who are ineligible to purchase insurance through the Marketplace.

If resources are available, RWHAP grantees and subgrantees are strongly encouraged to use RWHAP funds for premium and cost-sharing assistance for these individuals when it is cost-effective, as appropriate. As discussed above, the grantee and subgrantee must ensure that use of RWHAP funds for premium and cost-sharing assistance for these clients is cost-effective.

Conclusion

RWHAP funds may be used to help clients purchase and maintain health insurance, if cost-effective and in accordance with RWHAP policy. It is important for grantees and subgrantees to understand the new insurance options available to clients under the Affordable Care Act. Many clients may also be eligible to receive advance premium tax credits and/or cost-sharing reductions to help pay for private health insurance in the Marketplace. RWHAP grantees and subgrantees must take into consideration other sources of premium and cost-sharing assistance when determining how to operationalize a premium and cost-sharing assistance program. Grantees and subgrantees should also work directly with health insurance issuers and/or the Marketplace to coordinate payment of premiums and cost-sharing for clients.

[8] However, please note that legal residents with incomes below 100% FPL who do not qualify for Medicaid or other minimum essential coverage may be eligible for premium tax credits and cost-sharing reductions.

To learn more about the Affordable Care Act, grantees are encouraged to visit the HIV/AIDS Bureau's Affordable Care Act website (http://hab.hrsa.gov/affordablecareact/) and HealthCare.gov (http://www.healthcare.gov).

Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D

Policy Clarification Notice (PCN) #15-01

Supersedes July 17, 2012 Dear RWHAP Part A and Part B Colleagues letter regarding rent as an administrative cost

Scope of Coverage: Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D.

Purpose of PCN

This PCN revises and clarifies the Health Resources and Services Administration's (HRSA) guidelines for the treatment of costs under the statutory 10% administrative cap for RWHAP Parts A, B, C, and D.

Background

Parts A – D of Title XXVI of the Public Health Service (PHS) Act include a cap that limits the recipient (grantee) costs of administering the award to 10%[1]. With a rapidly changing healthcare environment, increasing requirements for oversight of subrecipients (including contractors performing programmatic activities), and required coordination across other federal, state, and local funding streams, RWHAP recipients have new and additional administrative costs. These additional activities coupled with current policies have resulted in unreimbursed administrative costs for RWHAP recipients and less flexibility in the use of HRSA funds to administer their grant(s). In an effort to provide increased flexibility for recipients, within the boundaries of the statute, the HRSA's HIV/AIDS Bureau (HAB) has re-examined the classification of costs subject to the 10% administrative cost cap.

It is important to note that the additional flexibility with regard to administrative costs will better enable recipients and subrecipients to provide core medical and support services to eligible clients while ensuring that the RWHAP is the payer of last resort.

[1] See §§ 2604(h)(1), 2604(h)(2), 2618(b)(3)(A), 2618(b)(3)(B), 2664(g)(3), and 2671(f)(1) of the PHS Act.

Instructions

Treatment of "Rent" and Other Facilities Costs Incurred to Provide Core Medical and Support Services to Eligible RWHAP Clients

RWHAP Parts A, B, and C Recipients (Grantees)
The portion of indirect and/or direct facilities expenses such as rent, maintenance, and utilities for areas primarily utilized to provide core medical and support services for eligible RWHAP clients (e.g., clinic, pharmacy, food bank, substance abuse treatment facilities) are not required to be included in the 10% administrative cost cap. [See 45 CFR §§ 75.412 – 414, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards* for information regarding the classification of costs as direct or indirect.]

RWHAP Parts A and B Subrecipients and Part D Recipients (Grantees) The portion of direct facilities expenses such as rent, maintenance, and utilities for areas primarily utilized to provide core medical and support services for eligible RWHAP clients (e.g., clinic, pharmacy, food bank, substance abuse treatment facilities) are not required to be included in the 10% administrative cost cap. Note: by legislation, all indirect expenses must be considered administrative expenses subject to the 10% cap.[2]

Clarifications

For all recipients (grantees) and subrecipients funded by RWHAP Parts A, B, C, or D, the following programmatic costs are not required to be included in the 10% limit on administrative costs; they may be charged to the relevant service category directly associated with such activities:

- Biannual RWHAP client re-certification;
- The portion of malpractice insurance related to RWHAP clinical care;
- The portion of fees and services for electronic medical records maintenance, licensure, and annual updates, and staff time for data entry related to RWHAP clinical care and support services;
- The portion of the clinic receptionist's time providing direct RWHAP patient services (e.g., scheduling appointments and other intake activities);

[2] See §§ 2604(h)(4)(A), 2618(b)(3)(D)(i), and 2671(h)(1) of the PHS Act.

- The portion of medical waste removal and linen services related to the provision of RWHAP services;
- The portion of medical billing staff related to RWHAP services;
- The portion of a supervisor's time devoted to providing professional oversight and direction regarding RWHAP-funded core medical or support service activities, sufficient to assure the delivery of appropriate and high-quality HIV care, to clinicians, case managers, and other individuals providing services to RWHAP clients (would not include general administrative supervision of these individuals); and
- RWHAP clinical quality management (CQM).[3] However, expenses which are clearly administrative in nature cannot be included as CQM costs.

For Parts A, B, and C recipients (grantees)—associated indirect costs may also be charged to the relevant service category.

For all recipients (grantees) funded by RWHAP Parts A, B, C, or D, costs subject to the 10% administrative cap include, but are not limited to:

- Routine grant 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 recipient's (grantee's) contract award procedures, including the development of requests for proposals, subrecipient and contract proposal review activities, negotiation and awarding of contracts;
- Subrecipient monitoring activities including telephone consultation, written documentation, and onsite visits;
- Reporting on contracts, and funding reallocation activities; and
- Related payroll, audit and general legal services.

[3] See §§ 2604(h)(5)(B)(ii), 2618(b)(3)(E)(ii)(II), and 2664(g)(3) of the PHS Act, which indicate that although CQM is considered an administrative cost, expenses for this activity do not count towards the administrative cost cap. Similarly, § 2671(h)(3)(B) of the PHS Act defines as "services" those services that contribute to or help improve primary care and referral services, and include CQM.

For Part A recipients (grantees), the cost of all activities carried out by the HIV health services planning councils and planning bodies would count toward the 10% administrative cap.[4]

For Part C recipients (grantees), planning and evaluation costs are subject to the 10% administrative cap.

All indirect costs charged by Part D recipients are considered an administrative expense subject to the 10% limit.[5]

Applicability to Subrecipients

RWHAP Parts A and B Subrecipients[6]

RWHAP Part A and B recipients (grantees) must ensure that the aggregate total of subrecipient administrative expenditures does not exceed 10% of the aggregate total of funds awarded to subrecipients. Subrecipient administrative expenses may be individually set and may vary; however, the aggregate total of subrecipients' administrative costs may not exceed the 10% limit.

Subrecipient administrative activities include[7]

- usual and recognized overhead activities, **including established indirect rates** for agencies;
- management oversight of specific programs funded under the RWHAP; and
- other types of program support such as quality assurance, quality control, and related activities (exclusive of RWHAP CQM).

As a reminder: all indirect costs charged by the subrecipient are considered an administrative cost subject to the 10% aggregate limit.

RWHAP Parts C and D Subrecipients

The 10% limit on administrative costs does not apply to subrecipients under Parts C and D. RWHAP Parts C and D grantees are responsible for ensuring that subrecipient administrative costs are allowable, reasonable, and allocable to the RWHAP. [See 45 CFR §§ 75.403-405 *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards* for information regarding basic cost considerations.]

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[4] See §2604(h)(3)(B) of the PHS Act.
[5] See §2671(h)(1) of the PHS Act.
[6] See §§ 2604(h)(2) and 2618(b)(3)(B) of the PHS Act.
[7] See §§ 2604(h)(4) and 2618(b)(3)(D) of the PHS Act.

Recipient (Grantee) Management and Oversight Functions

RWHAP Parts A, B, C, and D recipients (grantees) are responsible for establishing and maintaining written procedures for allocating and tracking funds applicable to the 10% administrative cost cap in compliance with RWHAP authorizing legislation and the requirements included in 45 CFR part 75 *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards*. Parts A and B recipients are also required to adhere to applicable requirements in the National Monitoring Standards.

If a RWHAP Part A or B recipient (grantee) has contracted with an entity to provide statewide or regional RWHAP management and fiscal oversight (i.e., the entity has entered in to a vendor or procurement relationship with the recipient, and is acting on behalf of the recipient), the cost of that contract, exclusive of subawards to providers, would count toward the recipient's (grantee's) 10% administrative cap. Providers that have contracted to provide healthcare services for the lead agency are considered to be first-tier entities (subrecipients) of the grantee and are subject to the aggregate 10% administrative cap for subrecipients.

Effective Date

All of the revisions and clarifications provided in this PCN are effective for RWHAP Parts A, B, C, and D awards issued on or after January 1, 2015. This includes competing continuations, new awards, and non-competing continuations issued on or after January 1, 2015. This PCN does not prevent a recipient (grantee) from adhering to current practice after the effective date. It is up to the recipient to determine how best to meet the needs of eligible RWHAP clients in compliance with RWHAP authorizing legislation, the requirements set forth in 45 CFR part 75, and all terms and conditions of the award.

Recipients (grantees) may not apply changes outlined in this PCN to costs incurred prior to January 1, 2015. Any findings from comprehensive site visits and/or audits related to administrative cost caps before January 1, 2015 remain in effect and will require resolution as documented.