

# **HIV Care Services Subrecipient Guidelines**

## **2016**



## **Division of Disease Prevention**

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## WHAT IS THE RYAN WHITE HIV/AIDS PROGRAM?



Ryan White was diagnosed with AIDS at age 13. He and his mother Jeanne White Ginder fought for his right to attend school, gaining international attention as a voice of reason about HIV/AIDS. At the age of 18, Ryan White died on April 8, 1990, just months before Congress passed the AIDS bill that bears his name – the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. The legislation has been reauthorized four times since – in 1996, 2000, 2006, and 2009 – and is now called the Ryan White HIV/AIDS Program (RWHAP).

The Ryan White HIV/AIDS Treatment Extension Act of 2009 Part B funding is intended to help states increase the availability of primary health care and support services in order to reduce utilization of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life of those affected by the epidemic.

The RWHAP is the largest federal program focused exclusively on HIV/AIDS care. The program is for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills gaps in care not covered by these other sources.

The RWHAP is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), and HIV/AIDS Bureau (HAB). For a thorough understanding of Ryan White legislation, you can visit the HRSA HAB website at: [www.hab.hrsa.gov](http://www.hab.hrsa.gov).

The 2009 Ryan White legislation changed how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS across the country. Key changes included:

- Revised method for determining eligibility for Part A funds gives priority to urban areas with the largest number of people living with HIV/AIDS while also helping mid-size cities and areas with emerging needs.
- Revised method for distributing Part A funds to metropolitan areas with the highest number of people living with HIV/AIDS. This encourages outreach and testing, which will get people into treatment sooner and save more lives.

- More money will be spent on direct health care for Ryan White clients. Under the 2009 law, grantees receiving funds under Parts A, B, and C must spend at least 75% of funds on core medical services.
- The 2009 law recognizes that HIV/AIDS has had a devastating impact on racial/ethnic minorities in the U.S. African Americans accounted for approximately half of all diagnosed HIV/AIDS cases. The 2006 law codified the Minority AIDS Initiative (MAI) under the RWHAP.
- Of primary importance is the provision that states must spend or obligate 95% or more of their grant award from HRSA. States with 5% or more of their grant funds unobligated at the close of the grant year will have future grant awards reduced by the amount of the unspent balance. Subrecipients and subcontractors should closely monitor their budgets to make every effort to spend allocated funds.

Virginia receives funds to improve the quality, availability, and organization of health care and support services for individuals living with HIV disease and their families. The Virginia Department of Health (VDH) oversees the implementation and funding for the Ryan White Part B (RWB) Program in Virginia under the guidance of HRSA. These funds are managed by the HIV Care Services (HCS) Unit of the Division of Disease Prevention (DDP).

With the enactment of the Affordable Care Act (ACA), people living with HIV disease now have access to secure, stable, and affordable health insurance. Insurance has become a growing part of the Virginia AIDS Drug Assistance Program (ADAP) and has proven to be a cost-effective way to provide expanded access for both medical care and medications. Virginia ADAP uses RWB funds to support costs for VDH-approved individual insurance plans purchased through the federal marketplace under the ACA. VDH selects insurance plans that meet HRSA and Virginia ADAP requirements. Selection of insurance plans is restricted by certain factors including coverage of ADAP formulary medications, geographic coverage within Virginia, and cost-effectiveness. VDH pays the monthly premiums and medication costs (copayments and deductibles) for these plans.

The DDP website <http://www.vdh.virginia.gov/disease-prevention/> provides a thorough overview of the mission and scope of services provided with and by RWB funding. On this site, you can review a map of the health regions, obtain fact sheets, order printed materials, view statistics on sexually transmitted diseases including HIV, how fundable services support the HIV Continuum of Care, and/or get detailed information on all programs that are currently managed by the DDP. Details of specific programs can be accessed through the Division homepage. Visiting the link <http://www.vdh.virginia.gov/disease-prevention/hiv-aids/> titled “HIV/AIDS Program” is highly recommended.

**VIRGINIA DEPARTMENT OF HEALTH DIVISION OF DISEASE PREVENTION  
HIV CARE SERVICES TEAM**

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**GENERAL CONTACT PHONE NUMBERS**

Medication Assistance (ADAP) Toll Free Hotline	(855) 362-0658
DDP HIV/AIDS Toll Free Hotline	(800) 533-4148

**FAX NUMBERS**

HIV Care Services	(804) 864-7629
Medication Assistance (ADAP)	(804) 864-8050
Medication Assistance (ADAP) Toll Free	(877) 837-2853

## RYAN WHITE PART B MINORITY AIDS INITIATIVE



Virginia Department of Health receives funds under the Ryan White HIV/AIDS Treatment Extension Act of 2009 Part B MAI Grant Program to provide case-finding, outreach and education services to increase access to HIV primary health care, ADAP and other prescription drug coverage for racial and ethnic minorities. MAI funding can only be used for education and outreach services for the specific purpose of increasing minority enrollment in ADAP, and only for the racial and ethnic minorities indicated in the legislation. Subrecipients design MAI funded services that meet the specific intent and parameters of the funding. Subrecipients must be able to trace the RWHAP Part B MAI activity to the client's enrollment into ADAP or another medication assistance program. Virginia's three MAI funded agencies target African-American, Hispanic, and Asian communities.

Two clinic based organizations and a health district focus on identifying and referring individuals at risk for or infected with HIV in order to link them to ADAP or other support sources, and those HIV-positive individuals who have been lost-to-care in order to re-engage them in ADAP and other needed care services. Linkage to medical care is supported by additional Part B funds to ensure complete access to treatment. MAI funded Patient Navigators in the Southwest region are trained to provide "HIV Rapid Testing".

Centra Health, Inc. (Southwest region), Inova Juniper Program (Northern region), and Richmond City Health District (Central region) are the three organizations providing MAI programming for 2016-2017.

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## STATE EARLY INTERVENTION PROGRAMS



Virginia Department of Health receives funds from the State General Assembly to support HIV Early Intervention Programs (EIPs) in Central and Southwest Virginia. Continued funding for EIPs ensures that individuals with HIV infection enter care as early as possible to live longer and healthier lives and to prevent the transmission of HIV to sex partners. An EIP has activities to increase an individual's awareness of their HIV status and, if needed facilitate access to the HIV care system using HIV testing, referral services, health literacy/education and linkage to care as a bridge to medical care, medication access and treatment adherence. EIPs enable clients to improve their health and remain adherent to their anti-retroviral medication regimen, which is critical to quality of life. These programs also provide Case Management Services that help newly-diagnosed clients apply for Medicaid, Medicare Part D, Social Security disability, and/or supportive services. The following organizations are providing early intervention services in 2016-2017.

### Arthur Ashe Program

Virginia Commonwealth University (VCU) Health System  
PO Box 980049, Richmond, Virginia 23298  
**Street Address:** 1101 E. Street, MCV Station,  
Richmond, Virginia 23298-0049  
Phone # (804) 230-2087  
Fax # (804) 230-2071

ATTN: **Dr. Veronica Ayala-Sims, M.D., Principal Investigator**  
Email: [vaayalas@vcu.edu](mailto:vaayalas@vcu.edu)

### Central Virginia Health District

PO Box 6056, Lynchburg, Virginia 24505  
**Street Address:** 1900 Thomson Drive,  
Lynchburg, Virginia 24505  
Phone # (804) 947-6777

ATTN: **Dr. Katherine V. Nichols, M.D., District Director**  
Email: [Katherine.Nichols@vdh.virginia.gov](mailto:Katherine.Nichols@vdh.virginia.gov)

### Health Brigade (Formerly Fan Free Clinic)

**Street Address:** 1010 N. Thompson Street,  
Richmond, Virginia 23230  
Phone # (804) 358-6343  
Fax # (804) 354-0702

ATTN: **Karen Legato, Executive Director**  
Email: [KLegato@healthbrigade.org](mailto:KLegato@healthbrigade.org)

## RYAN WHITE PART B AIDS DRUG ASSISTANCE PROGRAM



### **Program Overview:**

Virginia ADAP provides access to life-saving medications for low-income persons living with HIV who are uninsured or underinsured. Virginia ADAP is primarily supported through federal RWB grant funding. Ryan White funding resources are always considered the payer of last resort to pay for medications.

Virginia ADAP clients obtain medications through different mechanisms depending on program eligibility. There are several service options that fall under the scope of ADAP. In Virginia, medications are available for eligible clients through: (1) Direct ADAP that allows medication pick-up at a Local Health Department (LHD) or other designated medication access sites, (2) through Medicare Part D Assistance Program (MPAP) in-network pharmacies; and (3) through retail, specialty, or mail-order pharmacies in the state that are within the client's insurance plan network and within the Ramsell network through the Health Insurance Marketplace Assistance Program (HIMAP) or the Insurance Continuation Assistance Program (ICAP).

### **AIDS Drug Assistance Program Eligibility:**

With the exception of clients accessing medications through the Virginia Commonwealth University Health System (VCUHS), all ADAP eligibility and applications are processed within VDH HCS. VCUHS conducts initial eligibility determination for clients accessing medication through the VCU Pharmacy utilizing the Virginia ADAP application.

Virginia ADAP enrollment is currently open to all financially-eligible clients regardless of CD4 count. Virginia ADAP is able to provide assistance to clients with private insurance if the insurance plan meets formulary requirements and VDH's contracted pharmacy benefits manager can coordinate payments with the insurance company. **Based on Ryan White Program guidelines, clients must be certified annually and recertification for ADAP occurs every six months to receive Ryan White services. There is no grace period for annual certifications and re certifications, therefore if a client has not completed their annual certification or recertification at six months they may not be eligible for Ryan White services or ADAP.**

To be eligible for ADAP applicants must:

1. Live in Virginia.
2. Apply through the VDH Central Office or through VCUHS Financial Services.

3. Have an individual or family income at or below 400% of the Federal Poverty Level (FPL). See Attachment A-1, *FY 2016: Income Requirements by Federal Poverty Level (FPL)*, for specific income requirements. Eligibility criteria may also be found at [www.vdh.virginia.gov/ADAP](http://www.vdh.virginia.gov/ADAP).
4. Have documented CD4 count(s) and Viral Load (s) within the last six months.
5. Not qualify for or have Medicaid.
6. Provide proof of income, changes in insurance coverage, or any changes in residency every six months for recertification. All clients that file taxes must submit their most current 1040 tax return forms as proof of income.
7. Agree to participate in the insurance option that best meets the client's medical needs and for which the client is eligible.

**AIDS Drug Assistance Program Formulary:**

The formulary document includes the criteria required for each medication. Some medications on the formulary require additional medical criteria. If a clinician desires to prescribe any of these medications, an ADAP Medication Exception Form should be completed and submitted to Virginia ADAP for review and authorization. A copy of this form can be found at:

<http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/formulary/>.

Medications are dispensed from the VDH Central Pharmacy to the LHDs for client pick-up. In addition to LHDs, ADAP clients may also pick-up medications at VCUHS, Alexandria Health Department/Casey Clinic, Fairfax Health Department/Joseph Willard Health Center, and Inova Juniper Program sites in Herndon, Leesburg, Fairfax, Manassas, and Dumfries.

The non ADAP formulary is used when clients are enrolled in ICAP. ADAP therefore covers the costs of the formulary and non-formulary medication as long as the client is eligible for the program. A current list of the non ADAP formulary is found at:

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/documents/NonADAPFormulary.pdf> . ICAP is explained further in the following section.

Hepatitis C (HCV) medications are available on the ADAP formulary for co-infected individuals. In order to access these medications, the medical provider must submit an application to the HCV/HIV Co-Infected Treatment Assistance Program. Medications are shipped to either the medical provider's site or LHD. The application can be found at: <http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/hepatitis-chiv-co-infected-treatment-assistance-program/>.

**Policy Updates:**

ADAP policy updates, including new medications to the ADAP formulary, are routinely published and made available on the ADAP website. These updates are targeted towards

clinical providers, program staff, and new residents to Virginia seeking ADAP services. Each policy update is subject specific and is posted as approved for public communication. Please visit the Virginia ADAP webpage, <http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/>, periodically to review policy updates.

Over 6,000 clients receive services through the available ADAP service options detailed below. When an ADAP application is received VDH Central Office staff will determine which program a client is eligible for based on a review of the application and submitted documentation.

### **1. Direct Medication Provision/Direct AIDS Drug Assistance Program**

The program is administered centrally through VDH, with medications dispensed from the VDH Central Pharmacy to the LHDs for client pick up. In addition to LHDs, ADAP clients may also pick-up medications at VCUHS, Alexandria Health Department/Casey Clinic, Fairfax Health Department/Joseph Willard Health Center, and Inova Juniper Program sites in Herndon, Leesburg, Fairfax, Manassas, and Dumfries. Fairfax County and Alexandria are provided bulk ADAP medications from Central Pharmacy Services and dispense individual medications locally from in-house pharmacies.

VCUHS purchases and stocks medications and VDH Central Pharmacy replenishes medications as needed. For all other sites, prescriptions are ordered through Central Pharmacy Services by medication access site staff upon presentation of an ADAP formulary prescription by an ADAP eligible consumer. The Central Pharmacy fills prescription orders and ships back to the medication access site on a daily basis. Clients go to the medication access site to pick up their medications. The medication access site may require a consumer to verify his/her identity for the medication to be dispensed. This delivery system ensures that all clients in the state have access to medications, as access sites are located throughout every area of the state.

### **2. Medicare Part D Assistance Program (MPAP)**

MPAP provides financial support toward medication co-payments, deductibles, and premiums associated with a Medicare Part D plan for eligible individuals with income at or below 400% FPL. MPAP utilizes a variety of funding sources including pharmaceutical rebates, federal funds, and state funds. In order for a client to be eligible for MPAP, they must be enrolled into Medicare A or B, have a Part D plan, and not be eligible for a full low-income subsidy. Clients enrolled in MPAP may pick up medications at any pharmacy that accepts their Medicare Part D plan and is within the Ramsell network. Clients can contact Ramsell directly for a list of local participating pharmacies in their area. ADAP can pay monthly premiums for the Part D plan (if proof of premium is provided) and all medication cost shares for medications approved by their Medicare Part D plan. Virginia ADAP can serve two people under MPAP for the same cost as one person served by Direct ADAP. Current programmatic information and eligibility criteria may be found by visiting <http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/eligibility/>.

### 3. Insurance Assistance

#### **Insurance Continuation Assistance Program (ICAP)**

Individuals with certain private insurance with medication benefits are eligible for ADAP assistance with their medication copayments and deductibles if all other qualifications are met. This service allows ADAP to assist those with limited income to access medications at a retail, specialty, or mail-order pharmacy that is within the insurance carrier's network and the Ramsell network. If a client loses insurance, the client can access medications through Direct ADAP if the client continues to meet ADAP eligibility criteria. Virginia ADAP must be notified with any changes in insurance or income status. This assistance is subject to certain restrictions depending on the type of insurance policy held by the client. Medication copayment assistance covers medications on the ADAP formulary and the RWB Non-ADAP Formulary.

#### **Health Insurance Market place Assistance Program (HIMAP)**

ADAP has narrowed a selection of plans offered through the federal marketplace under the ACA that can be supported through Virginia ADAP. ADAP will pay the premiums and medication cost shares (deductibles and copayments) only for these approved plans which benefit ADAP clients the most. VDH will pay cost shares for any medication covered by the client's primary insurance. ADAP can serve two people under an insurance marketplace plan for the same cost as one person served by Direct ADAP.

To receive continued HIMAP support through ADAP, eligible clients are required to:

1. Enroll in a VDH approved plan.
2. Enroll in Individual plans only. ADAP will not pay for family plans (unless all family members currently receive medication through Virginia ADAP).
3. Apply any tax credits to premiums.
4. Use pharmacies within their insurance carrier's network and the Ramsell network.

A list of VDH approved plans may be found by visiting

<http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/affordable-care-act-2016/> <http://www.vdh.virginia.gov/>

A list of Ramsell network pharmacies can be located at

<http://www.ramsellcorp.com/individuals/va.aspx>.

#### **Medication Exception**

When a drug is not covered by an ACA insurance company's published formulary, the provider must complete a Medication Exception request through the insurance company providing all required information. The ACA necessitates expedited review (within 24 hours) in urgent circumstances, which is when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or the ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a non-formulary drug. Click on the link [Medication Exception and Prior Authorization](#)

[Guidance](http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/affordable-care-act-2016/) on the Virginia ADAP ACA webpage <http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap/affordable-care-act-2016/> for additional information and sample forms.

As part of the request for an expedited review based on urgent circumstances, the prescribing physician or other prescriber should support the request by including an oral or written statement that:

1. An urgency exists and the basis for the urgency (that is, the harm that could reasonably come to the enrollee if the requested drug were not provided within the timeframes specified by the issuer's standard drug exceptions process), and
2. A justification supporting the need for the non-formulary drug to treat the enrollee's condition, including a statement that all covered formulary drugs on any tier will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects.
3. If the Medication Exception request is denied, the provider must file an appeal within 24 hours and follow up with the insurance company. VDH requests in all cases where a drug exception has been denied that the Bureau of Insurance Ombudsman be contacted:
  - By Toll free phone at: (877) 310-6560, select option 1
  - By fax at: (804) 371-9944
  - By letter at: Office of the Managed Care Ombudsman, Bureau of Insurance, and P.O. Box 1157, Richmond, Virginia 23218
  - By email: [ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov)
4. Expedited Enrollment for Pregnant Women, Minors and Those Recently Released from Incarceration:

Pregnant women and minors are prioritized to ensure access to medications and to prevent treatment interruption. Medical providers may contact ADAP at 1-855-362-0658 to coordinate. Those recently incarcerated should contact the Care Coordination program detailed in the following section of the Contractor Guidelines.

All ADAP related information including forms, formulary, VDH approved ACA insurance plans, policies, and program updates may be found by visiting <http://www.vdh.virginia.gov/disease-prevention/virginia-aids-drug-assistance-program-adap> .

**ADAP Program Contact Information**

**Virginia Department of Health**  
HCS Unit, 1st Floor  
James Madison Building  
**Street Address:** 109 Governor Street  
Richmond, Virginia 23219-2448

Toll Free Medication Assistance Phone # (855) 362-0658  
Medication Assistance Fax # (804) 864-8050  
Toll Free Medication Assistance Fax # (877) 837-2853

**ATTN: Carrie Rhodes, Acting Assistant Director for Medication Access**

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## **CARE COORDINATION PROGRAM**



The goal of the Care Coordination program is to provide a seamless transition from incarceration to release from correctional facilities for persons living with HIV/AIDS (PLWHA) who have been and currently reside in Virginia. Care Coordination partners closely with the Virginia Department of Corrections (VADOC) and Virginia Regional and Local Jails (VRLJs). Referrals to the program are made prior to release or up to six months post release to ensure access to medications, continuation of medical care, and linkage to local case management.

The VADOC, VRLJs, and community partners refer eligible clients to the Care Coordination team by way of the Care Coordination referral packet, located on Virginia ADAP's web page at [www.vdh.virginia.gov/ADAP](http://www.vdh.virginia.gov/ADAP). HIV Care Coordinators authorize an additional 30 day supply of ADAP medications upon release which are shipped to the client's LHD. The HIV Care Coordinator expedites ADAP enrollment in order to continue access to medication and medical services. The HIV Care Coordinator follows clients for a minimum of 12 months ensuring that they are attending medical appointments and picking up medications. When other issues are identified, the client can be referred to local services in an effort to address potential barriers to care. Clients eligible for insurance through the ACA will be referred for special enrollment.

### **Care Coordination Contact Information**

#### **Virginia Department of Health**

HCS Unit, 1st Floor

James Madison Building

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## **RYAN WHITE PART B STATEWIDE QUALITY MANAGEMENT PROGRAM**



The mission of the VDH Quality Management (QM) Program is to promote continuous quality improvement by meeting the Ryan White HIV/AIDS Treatment Extension Act of 2009 requirements for QM. These requirements include: 1) measuring how well HIV health services meet the most recent Human and Health Administration Services Guidelines, and 2) developing strategies for improving access to quality HIV health services. The VDH QM Program envisions optimal health for all people affected by HIV/AIDS, supported by a health care system that assures ready access to comprehensive, competent, quality care that transforms lives and communities. This effort requires ongoing communication with consumers, employees, stakeholders, Consortia, sub-recipients and their subcontractors, QM Advisory Committee (QMAC), QM Leadership Team (QMLT), Peer Review (PR) Team, and providers.

The overarching purposes of QM efforts are to:

1. Ensure the highest quality care is provided to HIV/AIDS patients.
2. Solve problems over time through continuous performance measurement.
3. Enable monitoring of HIV-related illnesses through the use of demographic, clinical and service utilization data.
4. Assess consumer needs.
5. Build QM capacity within RWB-funded agencies statewide.
6. Identify opportunities to improve quality of care and delivery of services.

For 2016-2017, four Continuum of Care and one Oral Health Care Performance Measures (PMs) and indicators have been selected to monitor the quality of system integration of the RWB services delivery system. These selected measures assess Outpatient/Ambulatory Medical Care, ADAP, Health Insurance and Cost Sharing, Minority AIDS Initiative Outreach services, Emergency Financial Assistance, Medical Transportation, Medical Case Management and Non-Medical Case Management, Outpatient Substance Abuse Services, Mental Health Services, Oral Health Care, Health Education/Risk Reduction, Food Bank/Home-delivered Meals, Outreach Services, Legal services, and Medical Nutrition Therapy. See Attachment A-8, *Ryan White Funded Performance Measures for 2016-2017* for a complete list of performance measures. In

addition to the HIV Care Continuum, MAI clients who receive HIV education and outreach services will be verified as enrolled in ADAP or another prescription medication program.

Data from these measures will be used by the statewide Quality Management Advisory Committee to plan, design, measure, assess, and improve services and processes within RWB activities.

Additionally, all sub-recipients providing Medical and Non-Medical Case Management have been given until October 2016 to fully implement the new Case Management standards. As of October 1, 2016 all service providers are held accountable for implementing the Case Management Standards.

In accordance with HRSA policy, RWB funded subrecipients and subcontractors are required by VDH to develop, submit, and implement their 2016 QM Plans and Quality Improvement Projects (QIP) with measurable objectives. The progress made in developing QM Plans/QIP and in reaching identified outcomes, will be monitored by the HCS QM Coordinator and HIV Services Coordinators.

VDH has established three distinct processes that continuously monitor the QM Program. **First**, all funded agencies receive annual PR site visit reviews. To supplement the statewide PR information, HCS staff conducts annual site visits to Consortia Lead Agencies and each direct subrecipient. Additionally, Consortia Lead Agencies conduct site visits to their subcontractors on a continuous basis with the participation of VDH representatives during at least one annual subcontractor site visit. **Second**, individual client satisfaction surveys are conducted to determine client satisfaction at agency level. Needs Assessments are performed every two years at Consortia level to identify additional client needs, and isolate trends to identify opportunities for improvement. **Third**, Performance Measures (PM) are monitored statewide. Results of PR, QIP, PM, and HCS/Lead Agency site visits are reviewed and evaluated for deficiencies and successes. QM committees and stakeholders use this vital information to revise QM tools and improve the quality of HIV services.

With the changing health care environment spurred by the implementation of the ACA, the QM Program will be expanding to ensure quality service provision for care provided outside of the Ryan White network. A number of HCS QM documents and reports are available online through the HCS webpage at <http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/>.

Designated QM resources include:

- HRSA/HAB QM Manual: <http://hab.hrsa.gov/affordablecareact/>
- The National Quality Center of the New York State Department of Health: <http://www.NationalQualityCenter.org>
- Ryan White TARGET Center training: <https://careacttarget.org/category/topics/quality-management>

- The Local Performance Sites of the Mid-Atlantic AIDS Education and Training Center (MAETC): [www.pamaaetc.org](http://www.pamaaetc.org)
- Virginia Northern, Eastern and Central/Southwest Virginia HIV/AIDS Resource Consultation Center (VHARCC): [www.vharcc.com](http://www.vharcc.com)
- Virginia Department of Health Quality Management Plan: <https://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS/documents/pdf/2015%20Quality%20Management%20Plan.pdf>
- ADAP information can be found at [www.vdh.virginia.gov/ADAP](http://www.vdh.virginia.gov/ADAP)
- QM information can be found at: <http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/>

The overall QM activities reflect a continuous process, which improves and informs the delivery system of outcome results, and demonstrates a commitment to quality services for all individuals served within the RWB provider network. VDH, in collaboration with QM Committees, uses quality results to evaluate clinical and service data, identify gaps and barriers to attaining performance, communicate data analysis findings to stakeholders, and monitor the effectiveness of interventions.

### **Quality Management Program Contact Information**

**Virginia Department of Health**  
 PO Box 2448, Room 326, Richmond, Virginia 23218  
**Street Address:** 109 Governor Street,  
 Richmond, Virginia 23219-2448  
 Phone # (804) 864-7228  
 Fax # (804) 864-7629  
 ATTN: **Safere Diawara, QM Coordinator**  
 Email: [Safere.Diawara@vdh.virginia.gov](mailto:Safere.Diawara@vdh.virginia.gov)

## **RYAN WHITE PART B DATA MANAGEMENT SERVICES**



Part B of the Ryan White HIV/AIDS Treatment Extension Act 2009 requires that data be collected and reported to HRSA on a quarterly, semi-annual, and annual basis for all funded programs. The web-based data system, e2Virginia, developed by RDE Systems, LLC (RDE) in collaboration with VDH to collect and report client-level service data for care programs. The e2Virginia data system replaced the Virginia Client Reporting System (VACRS) legacy system in February 2016. VDH and RDE provide technical assistance and support for e2Virginia for all agencies statewide who utilize the system for their care program data entry and reporting needs.

In addition, VDH has developed and maintains a database for tracking ADAP client-level data and provides updated reports on active clients to LHDs and other medication distribution sites.

HIV Care Services also has its own data management and analysis group that analyzes and interprets statistical and fiscal data related to HIV service delivery and medication access programming including ADAP to evaluate program performance and forecast future needs.

### **e2Virginia Support Team**

For password resets, policy questions, account issues, or other technical issues,  
please contact:

Email: [support@e2Virginia.com](mailto:support@e2Virginia.com)

## **DATA TO CARE INITIATIVE**

The Data to Care (DtC) Initiative is VDH's strategy of using HIV surveillance data to identify out-of-care (OOC) clients in order to facilitate linkage and reengagement in care of persons living with HIV (PLWH) statewide. The DtC project was implemented to improve health outcomes for PLWH along the HIV Care Continuum by increasing the number of persons who are engaged in HIV care and have an undetectable viral load. Out-of-care lists are generated utilizing specific criteria and are distributed to subrecipients based on the most recent provider information available for each client. Using various methods, subrecipients will attempt to contact OOC clients to ascertain their current care status, and provide linkage and reengagement services for clients who are not currently engaged in HIV care. The Division of Disease Prevention DtC group meets bi-weekly to continually update DtC processes and procedures, evaluate program outcomes, and discuss future implementation and next steps.

Prior to receiving OOC lists, VDH subrecipients are required to participate in a DtC protocol training, provided by the DtC Project Analyst, which details DtC processes, expectations, and paper flow.

### **Virginia Department of Health**

**Street Address:** 109 Governor St, Richmond, VA 23219

Phone # (804) 864-7862

Secure Fax # (804) 864-7970

**ATTN: Amanda Saia, Data to Care Project Analyst**

Email: [Amanda.Saia@vdh.virginia.gov](mailto:Amanda.Saia@vdh.virginia.gov)



## RYAN WHITE PART B CONSORTIA



A Consortium is generally an association of public, nonprofit private health care and support services providers, community-based organizations, community individuals, and individuals infected and affected by HIV/AIDS. The Consortium analyzes gaps in medical and support services in its area and develops a comprehensive plan to address these gaps. Alternative funding other than Ryan White Part B dollars support consortia activities.

The Lead Agency for the Consortium conducts or updates an assessment of HIV/AIDS service needs for their geographical area, establishes a service delivery plan based upon prioritized services, coordinates and integrates the delivery of HIV-related services, assures the provision of comprehensive outpatient health and support services, evaluates its success in responding to service needs, and measures cost-effectiveness of mechanisms used to deliver comprehensive care.

The Northern Virginia HIV Care Consortium (NVHCC) and the Southwest/Piedmont HIV Care Consortium (SWVHCC) are the two Consortia currently operating in the Commonwealth.\*

For your convenience, points of contact for Consortia are provided below.

### Northern Virginia HIV Care Consortium

Northern Virginia Regional Commission  
(NVRC)  
**Street Address:** 3060 Williams Drive, Suite 510  
Fairfax, Virginia 22031  
Phone # (703) 642-0700  
Fax # (703) 642-5077  
ATTN: **Michelle Simmons, Director**  
**Human Services**

Email: [msimmons@novaregion.org](mailto:msimmons@novaregion.org)

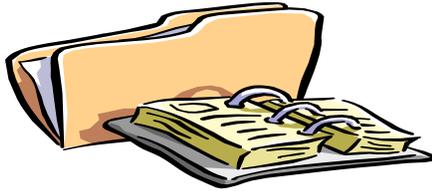
### Southwest/Piedmont HIV Care Consortium

Council of Community Services (CCS)  
PO Box 598, Roanoke, Virginia 24004  
**Street Address:** 502 Campbell Avenue SW  
Roanoke, Virginia 24004  
Phone # (540) 985-0131  
Fax # (540) 982-2935  
ATTN: **Pam Meador, Director**  
**CCS Drop-In Center**

Email: [pamm@councilofcommunityservices.org](mailto:pamm@councilofcommunityservices.org)

*\* VDH directly contracts with HIV service providers in the Northwest, Central, Eastern, and Southwest regions of the state.*

## **WHAT TO EXPECT FROM YOUR VDH HIV SERVICES COORDINATOR**



Your HIV Services Coordinator/Contract Monitor is your first point of contact with the VDH regarding any contractual matters. HIV Services Coordinators/Contract Monitors facilitate the coordination of services by contractors and in collaboration with other funders and community partners to better serve Ryan White and other individuals living with or at-risk for HIV infection. The HIV Services Coordinators also work with Prevention and HIV Surveillance/data staff to get the most updated information regarding VDH DDP matters. You can expect the following from your HIV Services Coordinator:

1. The HIV Services Coordinator will ensure that contract/Memorandum of Agreement (MOA) agreements are in place at least 15 days prior to the contract/MOA start date and that contract/MOA modifications are completed in a timely manner. The HIV Services Coordinator will review sub-recipient work plans and budgets and provide specific direction to sub-recipients to make any needed changes to these documents prior to finalizing contracts/MOAs. The HIV Services Coordinator will notify you when work plan revisions, budgets, and budget reallocations have been approved by the Division. (See more information under the Work Plan and Budget Reallocation Section.)
2. At the start of a new grant year, the HIV Services Coordinator will provide a list of the annual deliverables to VDH. These documents, which are due to VDH within 30 days of the signed contract/MOA, can be found at the VDH web site at the DDP HIV Care Services page:  
<http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/>.
3. The HIV Services Coordinator will address your questions or concerns in a timely manner and ensure that all actions you take are allowable according to the Contractor Guidelines and the VDH and HRSA Service Definitions. The HIV Services Coordinator will seek assistance and approval from other DDP staff when appropriate.
4. The HIV Services Coordinator will review your monthly reports to learn about your program's successes and challenges, assess progress toward meeting service delivery goals and rate of expenditures, make suggestions to improve service delivery, and address issues pertaining to compliance with Ryan White Part B or procurement requirements. The HIV Services Coordinator may request further

information or clarification about things in the report. The HIV Services Coordinator will provide written feedback within 10 business days after the receipt of the reports into the VDH office.

5. The HIV Services Coordinator and the VDH Fiscal Monitor will conduct a minimum of one site visit per year. This visit will be programmatic, administrative, and fiscal. During this visit, the HIV Services Coordinator and Fiscal Monitor will review program policies and procedures, time and effort sheets, fiscal invoices and any other documentation relating to the operation of your contract/MOA. The HIV Services Coordinator will provide written feedback of the site visit within 30 calendar days of the site visit. Site visits are designed to comply with HRSA National Monitoring Standards and are a requirement of the RWHAP Contract. For more information on the HRSA monitoring standards please go to:  
<http://hab.hrsa.gov/manageyourgrant/granteebasics.html>.
6. The HIV Services Coordinator will identify areas where current services do not meet client needs or acceptable standards and collaborate with sub-recipients to propose, develop, and implement strategies to address them. The HIV Services Coordinator will provide technical assistance, training and resources to sub-recipients to enhance knowledge about national and state policy and legislation (e.g., Ryan White, Affordable Care Act, National HIV/AIDS Strategy), improve staff skills (e.g., Case Management standards, data reporting, Quality Management) and agency capacity to effectively deliver services.
7. The HIV Services Coordinator will review monthly invoices to ensure that sub-recipients provide adequate documentation and bill only for allowable costs, and that invoices are paid in accordance with VDH Procurement and contract timelines.
8. The HIV Services Coordinator will serve as an HIV Care Services/VDH representative to Ryan White Part A Planning Councils, consortia, the state HIV Planning Group and other community organizations, on RFP panels, engage in Quality Management activities and training, and present updates on Ryan White Part B activities to clients and community agencies.
9. The HIV Services Coordinator will monitor and evaluate sub-recipient performance throughout the year and use this along with other data and information to recommend contract funding or modifications for the current and future grant periods.

## **WHAT VDH EXPECTS FROM ITS SUBRECIPIENTS**



### **Direct Service Providers (Subrecipients) and Subcontractors:**

The VDH DDP initiates direct agreements for services as well as contracting through Consortia. Direct Service Providers are those entities that have direct agreements (MOA of agreement or contract) with VDH. Under the reauthorized Ryan White Treatment Extension Act of 2009, at least 75% of the service dollars must be used to provide core medical services as described under Ryan White legislation. All statewide services, including core medical services, delivered through Consortia are deemed support services (PHS Act Sec. 2614 (a) [1-3]).

Direct Service Providers are ‘subrecipients’ of VDH. For the purposes of this manual, “subcontractors” are those entities that have agreements with subrecipients that contract directly with VDH. Subrecipients are responsible for ensuring that subcontractors comply with all terms of funding, including federal and state policies and legislation.

### **Subrecipient and Subcontractor Responsibilities:**

As part of the contractual process and at the beginning of each grant period, subrecipients are required to submit specific documents to VDH. A summary of documents and due dates for submission to VDH is included in Attachment A-16.

Subrecipient and subcontractor responsibilities include:

- Delivery of quality services to HIV/AIDS eligible clients.
- Ensure client eligibility.
- Meet deadlines in submitting progress reports and invoices.
- Comply with all components of the contract between VDH and the agency or the Consortium and the agency.
- Implement and maintain an invoice system using standard accounting practices; that when tallying receipts to request reimbursement on the invoice no rounding is allowed. VDH will reimburse the allowable costs specified on the supporting documentation provided with the invoice request. Invoices should only be sent to the secure email address [HCS-invoices@vdh.virginia.gov](mailto:HCS-invoices@vdh.virginia.gov); invoices should not be mailed or faxed.

- Support documentation for invoices with client identifying data should be sent by secure email ([HCS-invoices@vdh.virginia.gov](mailto:HCS-invoices@vdh.virginia.gov)) in the approved format/method described in the DDP *Security and Confidentiality, Policies and Procedures* guidelines. To send by secure email refer to the Appendix section A 4a of the Contractor Guidelines the process and steps to ensure your documents are sent in a secure format.
- Report program income receipts, expenditures, and balances on VDH invoice templates.
- Establish, implement, and evaluate a continuous quality improvement system.
- Participate with the PR process; as described in further detail in the Quality Management Sub-recipient Requirements section of this document.
- Ensure that all clients who receive services use any and or all available third party payer funds prior to using Ryan White funds.
- Collect and maintain back-up documentation for all invoices submitted to the fiscal agent for payment.
- Ensure confidentiality of all client records.
- Maintain current policies and procedures manuals; including client grievance procedures.
- Prepare and follow an annual work plan and budget approved by VDH or the Lead Agency.
- Comply with federal and state policies and legislation associated with funding.
- Maintain client level information in an approved database such as e2Virginia.
- Vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, Children’s Health Insurance Program (CHIP), Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, ACA marketplace, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services. Subrecipients must also assure that individual clients are enrolled in health care coverage whenever possible or applicable.
- Ensure all Ryan White Clients have been certified annually and re-certified every six months for ADAP and Ryan White eligibility.

**Quality Management Subrecipient Requirements:**

Subrecipients are expected to do the following as part of their agreement with VDH:

1. Subrecipient shall develop/update and submit an annual Ryan White QM Plan. The plan must include:
  - a. **Quality Statement** (Brief purpose describing the end goal of the HIV quality program);
  - b. **Quality Infrastructure** (Leadership, quality committees, roles and responsibilities, and resources);
  - c. **Performance Measurement** (Identifies indicators, who is accountable, how to report and disseminate, and process in place to use data to develop Quality Improvement (QI) activities);
  - d. **Annual Quality Goals** (Select only a few measurable and realistic goals annually and establish thresholds at the beginning of the year for each goal);
  - e. **Participation of Stakeholders** (Lists internal and external stakeholders and specify their engagement in the QM Program, include community representatives and partners, and specifies how feedback is gathered from key stakeholders); and
  - f. **Evaluation** (Evaluates the effectiveness of the QM/QI infrastructure to decide whether to improve how quality improvement work gets done and review PMs).
2. Subrecipient shall complete a program-specific QIP based on identified needs of client population and/or service delivery process challenge. The selected QIP will focus on enhancing medication adherence by utilizing standards from HRSA, including viral load suppression, CD4 count, frequency of medical appointments, and prescribing of highly active antiretroviral therapy (HAART) medication, as well as utilizing HIV medication adherence assessment data outputs, to track and assist in maintaining a selected percentage of medication adherence. QIP progress will be reported on a quarterly basis. A Plan, Do Study, and Act (PDSA) template is included in the Attachments (#A-7, *Quality Improvement Project Proposal and Reporting Template*) to help with QIP proposal development and reporting.
3. Subrecipient must submit a quarterly QIP progress report.
4. Subrecipient shall participate in statewide QM activities (meetings, trainings, improvement projects and data/report submission requests), to include the annual QM Summit and quarterly QMAC meetings.
5. Subrecipient shall include updates on QM plan implementation and monitoring each month through the submitted monthly progress reports.
6. Subrecipients shall participate in the RWB PR process which includes the collection of Ryan White Cross-Parts client-level performance measures, electronic medical record or chart audit, and patient peer interviews.

**FY 2016 Subrecipient Timeline for Quality Management Activity Deliverables**

<b>Quality Area</b>	<b>Quality Activity</b>	<b>Responsible Person</b>	<b>Timeline</b>
<b>Quality Management Plan (QM Plan) and Quality Improvement Project (QIP)</b>	Ryan White Provider Quality Management Plan development and submission to VDH	Subrecipients	60 days after the start date of the grant year
	Quality Improvement Project (QIP) proposal development and submission to VDH (selected topic is HIV/AIDS medication treatment and Adherence) The proposal should include the site baseline data on selected performance measures	Subrecipients	60 days after the start date of the grant year
	QM Plan and QIP Feedback	QM Coordinator	30 days after submission
	QIP and QM Plan updates required on monthly progress reports; QIP progress reports due quarterly.	Subrecipients	QIP quarterly reports are due: April 2016, July 2016 October 2016, January 2017
<b>Quality Monitoring</b>	Performance Measures (PM) Monitoring (via Monthly Report) & Feedback (via Monthly Report Response)	Subrecipients HIV Service Coordinators QM Coordinator	Monthly
<b>Planning and Evaluation</b>	Quality Management Advisory Committee (QMAC) Meeting	QMAC Members	May 10, 2016 February 10, 2017
<b>Quality Area</b>	<b>Quality Activity</b>	<b>Responsible Person</b>	<b>Timeline</b>
<b>Training</b>	QM Summit	QM Summit Planning Committee QMAC AETC/VHARCC QM Coordinator	September 13, 2016
	Case Management Retreat	QM Coordinator	March 2017
	Case Management Standards implementation	Subrecipients HIV Service Coordinators QM Coordinator	September 30, 2016
	Training and Technical Assistance as needed	QM Coordinator AETC/VHARCC	Ongoing

*QIP=Quality Improvement Project; QMAC=Quality Management Advisory Committee; AETC = AIDS Education and Training Center; VHARCC=Virginia HIV/AIDS Resource and Consultation Center; NQC=National Quality Center*

**Ryan White HIV/AIDS Program Services Report:**

Ryan White service providers are required to complete one Provider Report online on the Ryan White Service Report (RSR) Web-based System. All Ryan White service providers are expected to complete their own reports in order to confirm that their data accurately reflect their program and the quality of care their agency provides. Reports are typically due by March 10 of each year. Additional information about this requirement is included in the 2015 Annual Ryan White HIV/AIDS Program Services Report (RSR) Instruction Manual. The link to the RSR Instruction Manual is:

<https://careacttarget.org/sites/default/files/file-upload/resources/2015%20RSR%20Manual%20091215-508.pdf>

**Affordable Care Act Marketplace:**

Subrecipients and their subcontractors must also comply with “[Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program; Policy Clarification Notice \(PCN\) #13-04 \(Revised 9/13/2013\)](#)” issued to all Ryan White grantees that states in part:

*“Grantees should be aware that clients can only enroll in a private health plan during an open enrollment period, 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. 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 sub grantee processes to ensure that clients are enrolled in coverage options for which they qualify.”*

To support compliance with these policies, subrecipients shall perform the necessary steps to expand Ryan White HIV services to help enroll consumers into the Health Care Marketplace, and shall:

1. Notify and educate clients about the enrollment period and availability of plans;
2. Coordinate client needs in preparation for enrollment into the marketplace;
3. Assist clients with enrollment into the marketplace/plans by referring them to enrollment sites or, when possible, assisting them with enrollment;
4. Determine client eligibility in regards to health plans for which they may be eligible (including other payer sources) and Ryan White services;
5. Educate clients about the use of insurance to receive covered services;
6. Educate clients about requirements and processes involved with insurance coverage; and
7. During the open enrollment period, submit a weekly status report of health insurance plans to which clients are enrolled or referred and other enrollment-related activities to VDH including number of clients referred to and enrolled in health insurance sites and plans. See Attachment A-17 for a copy of the tracking log to be used for this purpose.

**Ryan White Part B Eligible Clients:**

For a client to receive RWB core or support services, the client must be HIV positive and meet program requirements listed below:

1. Live in Virginia.
2. Apply through the VDH Central Office or through VCUHS Financial Services.
3. Have an individual or family income at or below 400% of the Federal Poverty Level (FPL). See Attachment A-1, FY 2016: Income Requirements by Federal Poverty

Level (FPL), for specific income requirements. Eligibility criteria may also be found at [www.vdh.virginia.gov/ADAP](http://www.vdh.virginia.gov/ADAP).

4. Have documented CD4 count(s) and Viral Load (s) within the last six months.
5. Not qualify for or have Medicaid.
6. Provide proof of income, changes in insurance coverage, or any changes in residency every six months for recertification. All clients that file taxes must submit their most current 1040 tax return forms as proof of income.
7. Agree to participate in the insurance option that best meets the client's medical needs and for which the client is eligible.

Proof of HIV diagnosis is required, with appropriate documentation of proof further defined in the "Policy on HIV Diagnosis Documentation" developed by HCS and that follows HRSA and Centers for Disease Control and Prevention (CDC) 2013 diagnosis of HIV disease guidance. This policy may be obtained through HIV Services Coordinators (Contract Monitor) if needed. See Attachment A-1, *FY 2016: Income Requirements by Federal Poverty Level (FPL)*, for specific income requirements.

Clients who have access to private insurance coverage through an employer or family member should utilize this option before relying on Ryan White funding, as Ryan White funding is considered a payer of last resort. Ryan White HIV AIDS Program may cover costs not covered by an insurance provider.

**NOTE:** VDH service subrecipients and subcontractors are required to determine or verify Ryan White Part B eligibility at the client's initial assessment; and to recertify at least every 6 months. Please note that VDH determines Ryan White Part B eligibility for Virginia ADAP clients. Refer to the [Ryan White Part B HIV Case Management \(Medical and Non-Medical\) Standards of Service](#) for additional information. The Standards are located at <http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/health-care-services/>.

At least once a year (whether defined as a 12-month period or calendar year); the recertification procedures include the collection of more in-depth supporting documentation, similar to what is collected at the initial eligibility determination. To maintain eligibility for RWB services, clients must be recertified at least every six months. The primary purpose of the recertification process is to ensure that an individual's residency, income, and insurance status continue to meet the eligibility requirements and to verify that the RWB is the payer of last resort. The recertification process includes checking for the availability of all other third party payers.

In 2013, VDH approved self-attestation as a recertification method for the 6 month eligibility verification. VDH subrecipients can accept client self-attestation for the 6-month recertification. A VDH form was provided for this purpose and available online at

<http://www.vdh.virginia.gov/disease-prevention/eligibility/>. **Please note that a client must sign and date the self-attestation form in order for the 6-month recertification to be valid.** Please contact your HIV Services Coordinator for a copy of this form. Subrecipients must document the following:

- Self-attestation of “no change” in residency, income, or insurance status is all that is needed. No documentation such as proof of income or address is required to validate the ‘no change’ status by the client. Subrecipients need to document that self-attestation was completed, along with the results of the self-attestation (no change or change).
- Self-attestation of “change” – documentation is required from the client to verify/support the change in residency, income or insurance status; the necessary documentation submitted for a self-attestation of change is the same documentation that a client needs to submit at the initial eligibility determination and once a year/12 month period recertification.

Subrecipients and subcontractors need to ensure that the following is documented in a client’s file for the initial eligibility determination, once a year/12 month period, and 6 month self-attestation.

- HIV/AIDS diagnosis (at initial determination).
- Proof of residence (must reside in Virginia; client can receive Part B services anywhere in the Commonwealth).
- Low income (at or below 400% of the FPL).
- Uninsured or underinsured status (insurance verification as proof).
- Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare.
- For underinsured, proof that this service is not covered by other third party insurance programs including Medicaid and Medicare.
- Documentation that the process and timelines for establishing initial client eligibility, assessment, and recertification takes place at a minimum every six months; and
- Self-attestation statement of ‘no change’ in residency, income, or insurance status at the 6 month recertification or proof of “change” in any category above.

Examples of required documents for proof of income (for initial, 12 month, 6 month recertification) include:

1. **Employment income:** Copies of the three most recent, consecutive pay stubs that show gross income and payroll deductions. If it is unclear how often a paycheck is issued (weekly, biweekly, monthly, etc.), a statement may be obtained from the employer on company letterhead. If the employer does not provide pay stubs; a letter from the employer on company letterhead with the following items is required:
  - Gross monthly pay and how often client is paid.
  - A specific statement verifying that the employer does not provide actual pay stubs.
  - A statement that the applicant receives no health insurance through the employer.
  - The name, signature, job title, and phone number of the person writing the letter.
  - A complete copy of the most recent Federal Income Tax Return may also be considered as documentation.
2. **Self-employment income:** A notarized complete copy of the most recent Federal Income Tax Return is required (1040), including all applicable attachments.
3. **Veterans or other retirement benefits:** A copy of the benefit award letter or any other official documentation showing the amount received on a regular basis. If the benefit is being directly deposited into a bank account, a bank statement can be used as proof of benefit if the statement lists where the deposited amount is coming from.
4. **Net rental income (after expenses):** A complete copy of the most recent Federal Income Tax Return.
5. **Alimony/child support:** A copy of the benefit letter or any other official documentation showing amount received on a regular basis.
6. **Government benefits and/or award (such as Social Security and unemployment benefits):** Copies of the award letters showing current dollar amounts received. If the benefit is being directly deposited into a bank account, a bank statement can be used as proof of benefit if the statement lists where the deposited amount is coming from, such as with Social Security.

#### Proof of No Income

1. Termination or layoff notice from most recent employer on company letterhead.

2. A “proof of no income” letter that identifies the source of the applicant’s food and shelter. This signed letter can be provided by an agency or shelter on appropriate letterhead, and should have a contact phone number if verification is needed.
3. If the applicant is dependent on a relative, friend, or some other non-agency source of support, the individual providing the source of support must provide the “proof of no income” letter. This letter must include a statement of the relationship to the applicant and a certification as to the truthfulness of the letter; along with a statement describing the extent of the support and that there is no knowledge of any income received by the applicant.

For additional information concerning self-attestation, please refer to HRSA’s Policy Clarification Notice #13-02, *Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements*, (<http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>), HRSA’s National Monitoring Standards for determining eligibility (<http://www.hab.hrsa.gov/manageyourgrant/files/universalmonitoringpartab.pdf>), and the Virginia ADAP eligibility web page, <http://www.vdh.virginia.gov/disease-prevention/eligibility/>.

**Ryan White Imposition & Assessment of Client Charges:**

As per *HIV/AIDS Bureau, Division of State HIV/AIDS Programs, National Monitoring Standards for Ryan White B Grantees: Fiscal – Part B*, Section D: Imposition & Assessment of Client Charges, the following standards apply to subrecipient and subcontractor cost of care charges for RWB patients:

1. Recipient and sub-recipient 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.
2. No charges imposed on clients with incomes below 100% of the FPL.
3. Charges to clients with incomes greater than 100% of poverty are determined by the schedule of charges. Annual limitation on amounts of charge (e.g. 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.

*The HIV/AIDS Bureau, Division of State HIV/AIDS Programs, National Monitoring Standards for Ryan White B Grantees: Fiscal – Part B* can be found at <http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringpartb.pdf>.

**Subrecipient Progress Reports/Evaluations:**

Progress reports are due by the 30<sup>th</sup> of the month following the end of the month. Reports should be sent to the HIV Services Coordinator by electronic mail. The HIV Services Coordinator will print a hard copy to maintain on file (hard copies are an audit requirement). See Attachment A-5, *Instructions for Completing Subrecipient Report Narratives*, for additional information.

**A. REIMBURSEMENT FOR CONTRACTUAL EXPENDITURES**

**VDH Invoice Submission Guidelines**

See Financial Management of Your Grant section of this manual.

**Outpatient Ambulatory HIV Medical Care Fee-For-Service Reimbursement for Uninsured Clients**

The VDH, DDP, HCS Unit has implemented a fee-for-service payment process for outpatient ambulatory HIV medical care office visits reimbursed to service subrecipients. Fee-for-service is defined as a system of payment for professional services in which the practitioner is paid for a service rendered, rather than receiving salary and benefit reimbursement. The established reimbursement rates are based on Virginia non-facility 2016 Medicare rates. The rates are located on the Centers for Medicare and Medicaid Services CMS.gov website located at

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html>.

An allowable reimbursement fee-for-service rate is associated with a code that has an established definition with key components including complexity, severity, and time spent face-to-face. The Current Procedural Terminology (CPT) code set maintained by the American Medical Association through the CPT Editorial Panel has been used as a reference for the Virginia RWB code set to provide similarity to other billing activities of providers. The description of the CPT codes can be found on the American Medical Association website located at <https://ocm.ama-assn.org/OCM/CPTRelativeValueSearch.do>.

See Attachment A-14, *Outpatient Ambulatory Medical Care Fee for Service Policy and Fee Schedule*, for additional information.

**B. WORK PLAN AND BUDGET REALLOCATION REQUEST**

**Work Plan Revision:**

Subrecipients should send an email request indicating the proposed changes to their work plan to their HIV Services Coordinator for approval. VDH must approve all proposed changes prior to the subrecipient implementing these changes. The HIV Services Coordinator will provide written notification to the subrecipient once approval is granted. At this time, the subrecipient will need to provide a complete revised work plan to their HIV Services Coordinator.



### **Budget Reallocation:**

A completed budget reallocation form and revised service allocation table must be submitted to the HIV Services Coordinator for approval. The subrecipient must supply all information requested on the form. Budget reallocations must be submitted **no later than 30 days prior** to the end of the contractual year, unless approved by the HIV Services Coordinator. Contact the HIV Services Coordinator to discuss exceptional or extenuating circumstances. Budget reallocations may be submitted by fax or by e-mail with an electronic signature.

Please do not assume that submission of a budget reallocation request means automatic approval. New expenditures should not be made until the reallocation is approved; therefore, the budget should not be changed on the request for payment form until approved by the Division. Once the signature of the Program Manager or designated appointee has been obtained, a copy of the approved budget reallocation request form will be forwarded to the subrecipient. See Attachment A-3 for a copy of the Budget Reallocation Request form. An electronic version is available on the VDH/DDP webpage at the following address: <http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/>.

### **Carry-over Funds:**

Funds **cannot** be carried over to the following year. If you anticipate being unable to spend all funds by the end of the grant year, notify your Lead Agency or HIV Services Coordinator as soon as possible but no later than **120 days prior** to the end of the grant year.

## **C. OTHER SUBRECIPIENT INFORMATION**



### **Start-up Funds for New Contracts Only:**

Start-up funds are generally available for new agreements only. Start-up funds should be requested at the time of contract negotiations.

Once contracts/MOA have been signed by the DDP and VDH administration, the DDP will process start-up fund requests. Letters requesting start-up funds should be submitted along with the budget and work plan to the DDP Director.

### **Contract Renewals:**

Many contracts/MOAs allow for multiple renewals, depending on funding availability and other program factors. Contracts/MOAs are renewed at the discretion of VDH, generally based on performance.

The subrecipient is responsible for submitting a work plan, budget, executive compensation table, and service allocation table for the new contractual period. The work plan should include process and outcome objectives. Action steps/activities should be included under each process objective. Once all steps have been completed for the renewal process, an original signed contract will be forwarded to the subrecipient. Refer to the HIV Care

Services webpage, <http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/>, for VDH approved budget and work plan templates. Subrecipients are required to use these templates when submitting budgets for approval.

### **Contract Modifications:**

A contract modification occurs when there is a change in the scope of service or award amounts within the contract period. Subrecipients are required to submit a revised work plan and VDH budget template whenever a contract modification is requested. As part of the contract modification or renewal package, subrecipients are also asked to provide a revised allocation table that includes service costs, number of clients, number of units, cost per unit and client. If the cost per unit and/or client is high, provide a cost explanation that will be reviewed before approval.

### **Program Income:**

Subrecipients and their subcontractors are required to meet the standards and requirements related to program income referenced in the Code of Federal Regulations, 45 CFR 92.25, found at <http://cfr.vlex.com/vid/92-25-program-income-19932128>. Program income is any income generated by or earned as a result of the grant. This includes charges to beneficiaries under the sliding scale, as well as reimbursement from Medicaid, Medicare, private insurance, or third-party payers for services provided. Subrecipients must have a system in place to track and monitor grant specific receipt and expenditure of program income. Subrecipients are required to report all sources of service reimbursement as program income to VDH.

Program income should be budgeted as a resource with specific plans for expenditure, recorded in the accounting system, and designated as Ryan White for both receipt and expenditure. Acceptable tracking systems show program income amounts collected and expended as well as amounts apportioned by program either in the accounting system or summarized on a spreadsheet. All program income earned must be used to further objectives of the HIV program.

### **Payer of Last Resort:**

All subrecipients and their subcontractors must comply with the HRSA HAB's Policy 13-05 "[Clarifications Regarding Use of Ryan White HIV/AIDS Program \(RWHAP\) Funds for Premium and Cost Sharing Assistance for Private Health Insurance; Policy Clarification Notice \(PCN\) #13-05 \(Revised 9/13/2013\)](#)" issued to all Ryan White grantees that states in part:

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. This means subrecipients must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients.

The subrecipient and their subcontractors will demonstrate that RWB remains payer of last resort and complies with federal expectations. Part B subrecipients must coordinate funding and services with other funding sources and provide VDH with documentation of their

budgets, expenditures and program income from all Ryan White Parts (Ryan White Parts A, C, D, and F), their 340 B Program if part of their HIV service delivery program, and insurance revenue associated with HIV service provision for clients insured through the Virginia ADAP in an agreed upon frequency and format established by the subrecipient and the VDH.

**Audits:**

Agencies that receive more than \$100,000 in federal funding must submit a signed “Certification Regarding lobbying” form and, as appropriate, a “Disclosure of Lobbying Activities” to account for non-appropriated funds used for this purpose to the VDH within 90 days of the start of the funding period. Subrecipients are responsible to ensure they collect and submit this documentation for any subcontractors that receive more than \$100,000 in federal funding to VDH within the same time frame. (Forms/instructions that may be helpful include: <http://www.ecfr.gov/graphics/pdfs/ec01ja91.004.pdf> Instructions for Completion of Disclosure of Lobbying Activities; <http://www.ecfr.gov/graphics/pdfs/ec01ja91.003.pdf> Disclosure Form to Report Lobbying – Appendix B to Part 93; [http://www.ecfr.gov/cgi-bin/text-idx?SID=eceef378c6b4067f2eab5adf5aae8ca&mc=true&node=ap45.1.93\\_1605.a&rgn=div9](http://www.ecfr.gov/cgi-bin/text-idx?SID=eceef378c6b4067f2eab5adf5aae8ca&mc=true&node=ap45.1.93_1605.a&rgn=div9) Appendix A to Part 93 Certification Regarding Lobbying)

Subrecipients that receive more than \$500,000 per year in federal funding from all sources are required to have an A-133 audit conducted annually. The A-133 audits must include statements of conformance with federal financial requirements. A copy of the A-133 audit or the single audit and the Auditor management letter shall be submitted to VDH annually.

**Assurances:**

All subrecipients and subcontractors will certify annually with signed assurances that Ryan White funds are not used for unallowable expenses. See Attachment A-15 for a copy of the Assurances Statement. An online version is available at <http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/>.

**Employee Whistleblower Protection:**

Congress has enacted many whistleblower protection statutes to encourage employees to report fraud, waste, and abuse. Statute, 41 U.S.C. § 4712, applies to all employees working for contractors, grantees, subcontractors, and sub-grantees on federal grants and contracts. The National Defense Authorization Act (NOAA) for FY 2013 (Pub. L. 112-239, enacted January 2, 2013) mandates a pilot program entitled "Pilot Program for Enhancement of Subrecipient Employee Whistleblower Protections." This program requires all grantees, their sub-grantees, and subcontractors to:

1. Inform their employees in writing of employee whistleblower protections under 41 U.S.C. § 4712 in the predominant native language of the workforce, to include the specific requirements of the statute; and
2. Include this term and condition in any agreement made with a sub-subrecipient or sub-grantee.

The employees' rights under 41 U.S.C. § 4712 shall survive termination of a subrecipient's agreement.

**Non-Discrimination:**

In its performance of a contract or agreement, subrecipients will not discriminate against any employee or applicant for employment on account of race, color, sex, sexual orientation, gender identity, religion, age, disability, national origin, and political affiliation.

**Subrecipient Quarterly Meetings:**

Subrecipients are required to attend quarterly statewide subrecipient meetings. Updated contractual information and Division policies may be shared during these meetings. Technical assistance and/or capacity building/educational trainings are included in these meetings. Subrecipients are expected to arrive on time, sign in, and **remain for the full duration of the meeting.**

**Material Review:**

All educational materials supported with VDH funds must be approved by the **VDH Materials Review Panel**. Prior to release subrecipients will be responsible for any of the materials used by subcontractors. Educational materials include brochures, flyers, posters, video and audio tapes, questionnaires, surveys, curricula, or outlines for educational sessions, public service announcements, web pages, etc. This approval is required **prior** to purchasing and/or distribution.

To submit materials to the panel for approval, please contact your HIV Services Coordinator. Items should be submitted electronically for fastest response. If mailed, seven copies of documents are required for any items submitted on paper. The review process may take 10 to 30 business days, so please plan accordingly. It is helpful to describe the setting and audience for the materials. If materials are not approved by the review panel, subrecipients must not use grant funds to purchase or pay for the cost of developing, printing and/or distribution of the unapproved materials.

**Data Security and Confidentiality Guidelines:**

Subrecipients and subcontractors are required to comply with the VDH, DDP Data Security, and Confidentiality Guidelines. The DDP's Security and Confidentiality Guidelines (hereafter referred to as the Confidentiality Guidelines) are intended to ensure privacy, confidentiality, and security principles of the Division's patient level information, in accordance with Commonwealth of Virginia laws and regulations, as well as the CDC HIV/AIDS security guidelines related to HIV/AIDS.

This document serves as a reference to guidelines that ensure the confidentiality and security of information and data collected by and for the Division's programs. The guidelines also assist with the Division's compliance with relevant state and federal laws and regulations concerning the protection of confidential information. Guidelines will be made available to all subrecipients and subcontractors annually. All subrecipient and subcontractor staff that handle client identifying information is asked to sign and submit annually a **Verification of Receipt and Assurance of Key Requirements** statement to indicate that they have read the most current version of the Confidentiality Guidelines in its entirety, that they have read and

understood these key requirements, and that they have discussed any content that they did not understand with their supervisor. New hires throughout the grant period will also review and sign the Verification of Receipt and Assurance of Key Requirements statement as part of their RWB subrecipient orientation. The Guidelines are updated annually (springtime) and are posted online by DDP. Once that is done, subrecipients are notified and sent a link to the revised Guidelines.

### **Continuity of Operations Plan (COOP)**



Each subrecipient and subcontractor is required to prepare a Continuity of Operations Plan (COOP) to ensure continued access to essential services and care for all clients, including their Ryan White and State funded clients, in case normal operations cannot continue (in case of a disaster or emergency). This plan should be reviewed and updated annually. See Attachment A-9 for a list of resources for developing a COOP.

#### **Guidance for developing a COOP:**

1. Perform a risk assessment to evaluate systems or processes that might be vulnerable in an emergency situation. Determine what kinds of hazards pose the greatest risks for your agency/area. Identify “mission critical functions” and resources that are necessary to deliver services to clients. Dissect the steps and procedures necessary to perform these functions. Evaluate which systems and/or processes might be affected by an emergency or disaster. Consider and develop alternative or supplemental methods of performing these duties/tasks should normal service delivery mechanisms be interrupted.
2. Identify staff necessary to perform “mission critical functions.” Create a personnel roster and identify key individuals associated with completing the essential functions as well as backup personnel who could complete those tasks. Establish an identified chain of command of appropriate staff with pre-assigned duties and authority.
3. Develop and implement a system to protect records, assets, data, equipment, and facilities; include a plan for data backup and storage on and off-site in a secure location(s).
4. Create a key personnel emergency call list. Update the list at least annually. Develop an internal and external communication plan to notify staff, clients, funders and external agencies and stakeholders about the status of services and programs. List the

external agencies (federal, state, local, satellite offices, etc.) who must be notified when your work unit is unable to perform functions as usual.

5. Identify worksites (offsite or remote locations) to serve as alternative operations centers until services and programs can return to the original worksite. Develop relationships, agreements, and mechanisms with key organizations, stakeholders, and partnering agencies in order to ensure uninterrupted delivery of/access to services and care to clients.
6. Create an equipment and resource list that would be required for the essential personnel to function. Prepare a “to go” kit to maintain a mini operations center.
7. Assist staff and clients with creating their personal/family emergency needs plans. Disseminate disaster preparedness information to staff and clients. Encourage them to develop an emergency preparedness plan. Maintain a file of staff emergency preparedness plans and contact information in a secure location on and off site.

## WHAT TO EXPECT FROM CLIENTS



### **The client has the right to:**

- Be treated with respect, compassion, and sensitivity.
- Receive services and benefits without discrimination of any kind.
- Have all aspects of care and services treated with privacy and confidentiality.
- Have service providers' confidentiality policy explained.
- Make informed choices about what information is released and to whom.
- Be fully informed about all services available through the agency.
- Have agency grievance procedures explained.
- Have complaints responded to in a timely manner without risk of detrimental effect on client's services.
- Refuse care and /or discontinue services at any time.

### **The client has the responsibility to:**

- Treat agency staff and volunteers with respect and refrain from abusive language and behavior in communication or when communicating with them.
- Be an active participant in obtaining services and maintaining his/her personal well-being.
- Notify service providers of any changes to address, phone number, and health, financial or living situation.
- Apply for all eligible benefits within 30 days, including enrolling into an individual ACA marketplace insurance plan approved by the VDH during the open enrollment period or as a special qualifying event (approved by the ACA federal marketplace at [www.healthcare.gov](http://www.healthcare.gov) or (800) 318-2596.
- Keep appointments or cancel in advance; reschedule appointments for continuity of care.

- Respect the confidentiality of others.
- Provide adequate and accurate information to insure appropriate services are rendered.
- Provide feedback about the effectiveness of services rendered.
- Bring any complaint or grievance to the attention of the service provider.
- Allow your chart to be reviewed to ensure that services are being provided and bills are being paid according to the standards set by service providers.

## **FISCAL MANAGEMENT OF YOUR GRANT**



### **Financial Management System:**

Subrecipients and subcontractors are required to meet the standards and requirements for financial management systems referenced in the Code of Federal Regulations, 45 CFR 74.21, found at <http://cfr.vlex.com/vid/74-21-standards-financial-management-systems-19932432>.

These standards require that adequate financial processes must be maintained in order to:

1. Provide accurate, current, and complete financial information about the award and provide necessary financial reports.
2. Maintain records that adequately identify the sources and purposes for which the award was used including appropriate authorizations and obligations. The accounting records must be supported by proper source documentation.
3. Maintain and ensure effective internal controls over all funds, property, and other assets (All assets must be used solely for authorized purposes).
4. Reconciliation of actual expenditures with approved budgets for each grant award.

### **Financial Records:**

All subrecipients and subcontractors are subject to OMB Circular A-133 which requires that an A-133 audit be conducted for all recipients and subrecipients receiving more than \$750,000 per year in federal grants (all federal funds). A copy of the latest A-133 audit must be submitted to their HIV Services Coordinator.

Subrecipients and subcontractors agree to retain all financial books, records, and other financial documents relative to their Agreement for five years after final payment, or until audited by the Commonwealth of Virginia, whichever comes first. Office of Epidemiology (OEpi), authorized agents, and/or State auditors have full access and the right to examine any of aforementioned materials during stated period. Fuel gift cards used for client medical transportation reimbursements must be kept in a secured area at all times and recorded in a log available for review. The Fuel Gift Card logs and records must be available for review by the HIV Services Coordinator during annual site visits or upon request. An example of the Fuel Gift Card Log is located in the Attachment A-18.

### **Budget Development:**

Each subrecipient and subcontractor must develop a budget that will ensure compliance with uniform administrative requirements to reconcile actual expenditures or outlays with budgeted amounts for each grant or sub-grant. The developed budget will be part of the grant application or competitive procurement process and as part of a grant renewal process.

Subrecipients and subcontractors must develop a budget for each grant that it receives based on the allocations they receive from VDH and estimations of program income. The budget shall provide a description of how the program income will be used to further the objectives of the RWB Program. Refer to the HIV Care Services webpage, <http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/>, for VDH approved budget templates. Subrecipients are required to use these templates when submitting budgets for approval. VDH recommends the following procedures for budget development:

- Identify expected allocations by contract, category and year of appropriation; provide the methodology/basis used to allocate costs for different services for the entire program's budget and the percentages applied to the funds to be allocated for a particular RWB service category;
- Identify expenditures by functional classification and cost category;
- Develop written budget justifications that specify the process by which the budget is developed, approved, implemented, monitored and revised; and
- Submit and maintain supporting documentation for budgeted amounts.

All awarded monies must be obligated or spent by the last day of the grant year. "Funds obligated" means there is written documentation between the subrecipient and a vendor/provider for the service or products; however, the subrecipient has not yet received the actual bill or invoice. Unexpended funds may not be carried over to the next funding year.

Office of Management and Budget (OMB) cost principles (A-87, State, Local and Indian Tribal Governments; A-122, Non Profit Organizations & A-21, Cost Principles for Educational Institutions), HHS Program Regulations, and the terms of the contract will be used to determine if costs are reasonable, allocable, or allowable.

These categories are provided to ensure appropriate ordering of budget categories and placement of line items (Attachment A-2). This document also describes what each line item entails. The invoice should reflect the line items in the approved budget.

### **Indirect Costs:**

Indirect costs are capped at 10% and may be applied when the subrecipient has a certified HHS-negotiated rate approved by the HRSA using the Certificate of Indirect Costs. The approved Certificate of Indirect Costs must be submitted to VDH with your invoice for reimbursement. Nonprofit organizations that do not receive funds directly from the federal government are not eligible to request an indirect cost plan rate.

### **Administrative Costs:**

Organizations that do not have an approved indirect cost allocation plan may request reimbursement for actual administrative expenses (capped at 10% of total budget) with appropriate source documentation. The administrative expenses must be allocated with an appropriately documented methodology to ensure that only appropriate and allowable share is charged to the Ryan White program. Eligible allowable administrative expenses include:

- Costs for **program specific** management oversight including program coordination, clerical, financial, and management staff not directly related to patient care
- Program evaluation
- Liability insurance
- Audits
- Computer hardware/software not directly related to patient care
- Rent and Other Facilities Costs- As per HIV/AIDS Bureau PCN 15-01, *Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D*, 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.] For further information refer to <http://hab.hrsa.gov/healthcarelandscape/pcn1501.pdf>.

***(All requests for computer hardware, software, or similar equipment must be submitted to VDH for prior approval to ensure that it is eligible for reimbursement. Documentation of prior approval must be submitted with the invoice.)***

### **Note:**

- a. *Policy Clarification Notice (PCN) #15-01, Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D*, requires Ryan White Part B recipients to establish and maintain written procedures for allocating and tracking funds applicable to the 10% administrative cap in compliance with Ryan White authorizing legislation and the requirements included in 45 CFR part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. Ryan White Part B recipients must adhere to applicable requirements in the National Monitoring Standards.
- b. No more than 10% of the total amount allocated to subrecipients is allowable for administrative costs. If a subrecipient receives a Quality Management (QM) allowance, that amount cannot exceed 5% of the total allocation to the subrecipient.

Therefore, if a subrecipient is allocated a total of \$100,000, they can budget up to \$10,000 to administrative costs, and up to \$5,000 to QM costs.

**Costs Not Allowed:**

The following costs are **not allowable** under the RWB Program:

- Cash payments to service recipients (*Note: A cash payment is defined as the use of some form of currency {paper or coins}*). Gift cards that have an expiration date; therefore, they are not considered to be cash payments.
- No gift cards are allowable with the VISA, Master Card, Discover, American Express or other branded credit card company logo.
- Funds may not be used to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility (*other than minor remodeling which requires approval*).
- Funds may not be used for non-targeted marketing promotions, advertising (*poster campaigns for display on public transit, TV or radio public service announcements, etc.*) and broad-scope awareness activities about HIV services that target the general public.
- Funds may not be used for outreach activities that have HIV prevention education as their exclusive purpose.
- Funds may not be used to influence or attempt to influence members of Congress or other federal personnel.

**\*The items listed above are not intended to be all inclusive but to provide guidance. For further information please view the HIV/AIDS Bureau Policy 16-02 at [http://hab.hrsa.gov/healthcarelandscape/service\\_category\\_pcn\\_16-02\\_final.pdf](http://hab.hrsa.gov/healthcarelandscape/service_category_pcn_16-02_final.pdf)**

**Salaries and Fringe Benefits:**

For salaries and fringe benefits, a spreadsheet or word document must be submitted that includes the employee name (as it appears on the payroll-no nicknames), with the amount of salary and fringe benefits that are being charged to the contract broken down by person. The spreadsheet should have a column for salary, fringe benefits, and total per employee. If an employee's salary and fringe benefits are allocated to more than one grant, an additional column must be added to show the remainder of the salary and fringe benefits distributed to "other funding streams".

It is not required to identify specific grant programs categorized in "other funding streams". It is not necessary to submit timesheets and other documents with the reimbursement request; however, these documents may be requested by your HIV Services Coordinator if deemed necessary and must be maintained and available for review during the monitoring site visits.

A statement must be included with the spreadsheet that verifies that time and effort is being maintained on site for all of the employees that are being charged to the grant and will be available for review on site. Below is an example of the required submission:

April, 2015							
Employee		Grant #1 (enter grant title)		Other Funding Streams		Total	
Last Name	First Name	Salary	Fringe	Salary	Fringe	Salary	Fringe
Trump	Peter	\$ 270.00	\$ 32.40	\$ 270.00	\$ 32.40	\$ 540.00	\$ 64.80
Bush	Taylor	\$ 175.50	\$ 21.06	\$ 175.50	\$ 21.06	\$ 351.00	\$ 42.12
Hall	Alan	\$ 367.50	\$ 44.10	\$ 367.50	\$ 44.10	\$ 35.00	\$ 88.20
Hale	Danny	\$ 185.95	\$ 22.31	\$ 185.95	\$ 22.31	\$ 371.90	\$ 44.62
Timely	Elvis	\$ 195.00	\$ 23.40	\$ 195.00	\$ 23.40	\$ 390.00	\$ 46.80
Esther	Brenda	\$ 396.50	\$ 47.58	\$ 396.50	\$ 47.58	\$ 793.00	\$ 95.16
Freely	Isaac	\$ 39.00	\$ 4.68	\$ 39.00	\$ 4.68	\$ 78.00	\$ 9.36
Romig	Karen	\$ 177.83	\$ 21.34	\$ 177.83	\$ 21.34	\$ 355.66	\$ 42.68
Parker	David	\$ 948.75	\$ 113.85	\$ 948.75	\$ 113.85	\$ 1,897.50	\$ 227.70
Hayes	Rachel	\$ 236.74	\$ 28.41	\$ 236.74	\$ 28.41	\$ 473.48	\$ 56.82
Woods	Sharon	\$ 546.00	\$ 65.52	\$ 546.00	\$ 65.52	\$ 1,092.00	\$ 131.04
Buquet	Mercy	\$ 84.50	\$ 10.14	\$ 84.50	\$ 10.14	\$ 169.00	\$ 20.28
<b>Total</b>		<b>\$ 3,623.27</b>	<b>\$ 434.79</b>	<b>\$ 3,623.27</b>	<b>\$ 434.79</b>	<b>\$ 6,546.54</b>	<b>\$ 869.58</b>

\_\_\_\_\_ certifies that Time and Effort records are completed and maintained on site for VDH review during monitoring visits. The Time and Effort records confirm the percentage of time and funding source for the employees shown above. VDH will have access to these records for up to five (5) years following closeout of the grant.

\_\_\_\_\_  
Signature Title Date

**NOTE:** If salaries are being reimbursed for staff such as a physician and they bill Medicaid or another provider and receive a reimbursement it is considered program income. All program income must be tracked to show how it was earned and expended. The contractors are allowed to use the program income to provide allowable services or as additional administration above the 10% cap. They can use it for rent, etc. If this situation exists, it must be reported to your HIV Services Coordinator.

### **Travel:**

Documentation must be provided to show proof of payment of the travel reimbursement (a copy of the reimbursement voucher, itemized hotel bills obtained at the time of checkout, rental car receipts, meal receipts and gas receipts if applicable). If hotel rooms are obtained through internet providers (Priceline, Expedia, Orbitz, Travelocity, etc.) the traveler must submit a copy of the final page from the Internet site that shows total costs and confirmed services. Mileage may be reimbursed at the Commonwealth of Virginia rate which is 54.0 cents per mile (for first 15,000 miles) effective January 1, 2016 for business travel. An analysis must be conducted to determine the most cost effective mode of transportation (rental car or personal mileage) for each trip that exceeds 100 miles. The analysis must be submitted with the invoice. Receipts are required for parking and toll expenses that exceed \$20.00.

The purpose of the trip must be documented on the travel voucher and clearly identify which portion of the travel is related to the RWB program. Any unusual charges on the travel voucher must be fully documented. The travel voucher must contain the number of miles traveled point to point. A MapQuest printout will be required if the miles requested for reimbursement exceed 100 miles per day.

If reimbursement is requested for VDH pre-approved training or meeting attendance, an agenda must be submitted including information about any meals that were provided or included in the registration fee, the location and the purpose should be clearly documented.

Taxi fare for staff travel will not be reimbursed except for some situations concerning out of town travel (such as travel from an airport to a hotel). Justification for use of taxis out of town must be submitted with your invoice.

If business is conducted over a meal, the subrecipient can submit a business meal reimbursement. Subrecipients will need to provide documentation that includes an original, itemized receipt of meal (which can include tip and delivery costs if applicable), list of people present at the meal, and reason for the meal (for example, what business topics were discussed), and approval by their Agency head or designee. Subrecipients can be reimbursed for actual expenses up to the amount shown for the applicable meal in the M&IE Rate Table, excluding the incidental allowance.

Any travel expenses will be reimbursed as per the current, state approved travel regulations available in the [Commonwealth Accounting Policies and Procedures \(CAPP\) Manual](#), Travel Regulations, General Accounting section, by clicking on the link:

[http://www.doa.virginia.gov/Admin\\_Services/CAPP/CAPP\\_Main.cfm](http://www.doa.virginia.gov/Admin_Services/CAPP/CAPP_Main.cfm) (Topic #20335).

Travel reimbursements cannot exceed the established limits.

### **Equipment:**

All requests for computer hardware regardless of acquisition cost must be submitted to VDH for **prior approval** to ensure that they are eligible for reimbursement. Documentation of prior approval must be submitted with the invoice. Provide a copy of the receipt and proof of payment for equipment and any related expenses in this category.

**Supplies:**

Provide a copy of the receipt and proof of payment for all supplies or incentives such as gift cards. Cash payments may not be made directly to clients. Gift cards (e.g. food store, gas) normally have an expiration date; therefore, they are not considered to be cash payments. Contact your contract monitor for approval before purchasing gift cards for your program.

**Contractual:**

Provide a copy of the subcontractor's invoice for services rendered and proof of payment. If a contractual cost is recurring; provide a copy of the contractual agreement annually to the HIV Services Coordinator. For Consortia, it is incumbent upon the Lead Agency to certify that they have reviewed and agree with the subcontractor charges they are submitting to VDH for payment. The Lead Agency must sign the subcontractor invoice or include a statement or an e-mail that they reviewed and agree with the submitted charges.

**Other:**

Provide a copy of the invoice for services and proof of payment. If the payment is for rent, provide a copy of the lease or rent agreement indicating the agreement period and rental amount (annually). Provide a copy of the check or record of electronic transmittal of the payment with the month of the payment noted on the memo line with the monthly or quarterly invoices.

For utilities including telephone, water, electric, etc., provide a copy of the invoice and proof of payment. The month that the payment is related to must be noted on the invoice. The entire invoice must be provided as part of the documentation.

<p><b>NOTE:</b> Late fees and penalties charges are not allowable expenses. Charges must be reasonable and directly related to the grant purpose. Contractors that divide costs for specific line item across multiple grants programs/funding sources should indicate on the documentation what portion or amount is being charged to the request being submitted.</p>
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**VDH Invoice Submission Guidelines**

**Invoice Submission:**

Monthly invoices are due by the 30<sup>th</sup> of the following month as specified in the Contract or MOA. Please refer to the Division Contract Line Item Format when submitting invoices for payments (Attachment A-2). The time frame should correspond to the funding time period of your contract.

Payments to subrecipients will be based on invoices submitted, completion of objectives and submission of required reports. VDH may elect to withhold payment if contractual obligations are not met (e.g., if the contractually required monthly reports are not submitted, payment may be withheld until they are received).

All invoices, requests for payment and supporting documentation must be emailed as secure/encrypted to [HCS-Invoices@vdh.virginia.gov](mailto:HCS-Invoices@vdh.virginia.gov) . **Faxed and mailed invoices and documentation will not be accepted.** Contact the HCS Business Manager for questions related to invoicing.

Invoices must include:

- The grant program name
- FIN/EIN number
- **Full** contract number to ensure correct routing to the HIV Services Coordinator.
- Supporting documentation/proof of payment (*This section is in review. Contact the HCS Business Manager for questions related to what documentation is needed to reimburse for expenditures made with RWB funds*)
- Name, phone number and email address of the individual to contact with any questions.
- Reimbursement requests for the exact amount of money spent in each budget line item. VDH does not allow subrecipients to round costs to the nearest dollar.
- Actual program income received and expended during the month or billing period. The revenue and expenditures shall be traceable through the subrecipient's medical practice management system or other auditable system.
- Each invoice will have a unique, never duplicated, invoice number. This number will be placed on the "Invoice # line" at the top of the invoice.
- The invoice number will be named as follows: The first 3 or 4 initials of the organization, and then a three digit number (i.e. ARE001, EVMS001). With each invoice submitted, the three digit number will increase by 1 to provide a unique invoice number to that invoice only.
- Regardless of how many different contracts you may have with Virginia Department of Health, an invoice number shall **never** be duplicated.
- All invoices should be addressed to the DDP Director Diana L. Jordan. Monthly payments will be reimbursed 30 calendar days from receipt of the invoice by the DDP, HIV Services Unit. Disputes regarding invoices may delay payment. In the case of a dispute, the due date will be 30 days from the date the dispute is resolved. The process for disputed invoices includes:
- The HCS HIV Services Coordinator and Fiscal Accountant will review the invoice for accuracy and allowability and forward to the fiscal office within seven days.

The HIV Services Coordinator or Fiscal Technician will communicate directly with the subrecipient if a discrepancy is found during the review process until resolved. If the discrepancy cannot be resolved within 3 days, the item cost in dispute will be removed from the invoice and resolved in the following invoice.

- All dispute information will be documented on the back of the original invoice and forwarded to the fiscal office after resolution.
- Additional discrepancies discovered in the fiscal office will be forwarded to the HIV Services Coordinator or Fiscal Technician to communicate directly with the subrecipient for resolution.
- It is the subrecipient's responsibility to update the information provided on their invoice sheet so that it will reflect all correct information for their next submission. Failure to provide an updated correct invoice will require resubmission, and may delay payment.

### **Final Invoices:**

Subrecipient final invoices are due no later than 45 days after the grant period ends. Obligated funds must be spent by the end of the last month in the grant period with one exception. Oral health treatment plans approved and in place prior to the end of the grant year are considered obligated; subrecipients have **45 days** after the grant period ends to complete the treatment plan and submit bills with the final invoice.

### **Payment:**

Since subrecipients will be receiving multiple payments over the course of the year, the Commonwealth of Virginia has mandated that they be set up to receive electronic payments. The Virginia Department of Accounts (DOA) handles the set-up of the Electronic Data Interchange (EDI) payments. VDH has no responsibility other than to notify and monitor for compliance. Subrecipients are encouraged to visit the DOA, EDI web page at [http://www.doa.virginia.gov/Admin\\_Services/EDI/EDI\\_Main.cfm](http://www.doa.virginia.gov/Admin_Services/EDI/EDI_Main.cfm) for information concerning this requirement.

### **General Compliance Mandates**

- Each subrecipient and subcontractor is required to prepare a Continuation of Operation Plan (COOP) to ensure continued access to essential services and care for all clients, including their Ryan White and State funded clients, in case normal operations cannot continue (in the event of a disaster or emergency). This plan should be reviewed and updated annually.
- “Any expenditure deemed unallowable by VDH or its federal granting agency due to unallowable activities or misuse of funds by subrecipients or their subcontractors shall be repaid to VDH with non-federal funds in a timeframe prescribed by VDH.

VDH will utilize any remedy prescribed by statute to ensure recovery of funds deemed unallowable.”

- “Subrecipients and subcontractors receiving RWB funds are subject to all federal financial rules and regulations as if they were direct RWB grant recipients. Grantees can find relevant information regarding the administration of grants in the following OMB Circulars. (<http://www.whitehouse.gov/omb/circulars>).
- OMB Circular A-102 - *Grants and Cooperative Agreements with State and Local Governments* (codified by the U.S. Department of Health and Human Services [HHS] in 45 CFR Part 92), and
- OMB Circular A-110 - *Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations* (codified by HHS in 45 CFR Part 74). A-110 applies to sub-awards and contracts made by state and local governments to organizations covered by this Circular.
- Subrecipients and subcontractors must review the Ryan White monitoring standards and ensure systems are in place to comply with all requirements. Links are provided below to ensure access to required information. At a minimum, requirements outlined in these policies will be reviewed and measured for compliance during annual site visits conducted by VDH. More frequent monitoring may be conducted at the discretion of VDH. Ryan White National Monitoring Standards are located at:

<http://hab.hrsa.gov/manageyourgrant/files/universalmonitoringpartab.pdf>  
<http://hab.hrsa.gov/manageyourgrant/files/programmonitoringpartb.pdf>  
<http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringpartb.pdf>

- Salary Limitation from HRSA requirements: The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Executive Order 13655 enacted January 12, 2014 revised the Executive Level II compensation amount. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is \$185,100. This amount reflects an individual’s base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to sub-awards/subcontracts under a HRSA grant or cooperative agreement.

Example of the application of this limitation: If an individual’s base salary is \$350,000 per year plus fringe benefits of 25% (\$87,500) and that individual is devoting 50% of their time to this award, their base salary should be adjusted to \$183,300 plus fringe of 25% (\$45,825) and a total of \$114,562.50 may be included in

the project budget and charged to the award in salary/fringe benefits for that individual. See the breakdown below:

Actual base full time salary for individual devoting 50% of their time to project = \$350,000.00

	Actual	Adjustment for limitation (Executive Level II)	Project Allowable Expenses reflective of 50% time on project
Base	\$350,000.00	\$185,100	\$ 9, 92,550.00
Fringe (25% of salary)	\$ 87,500.00	\$ 45,825.00	\$ 22,912.50
Total	\$437,500.00	\$229,125.00	\$115,462.50

# **ATTACHMENTS**

Attachment No.	Attachment Name
A-1	FY 2016 Income Requirements by Federal Poverty Level (FPL)
A-2	Budget Line Item Format
A-3	Budget Reallocation Request
A-4	Invoice Template
A-5	Instructions for Completing Subrecipient Report Narratives
A-6	Subrecipient Report Narrative Template
A-7	Quality Improvement Project Proposal and Reporting Template
A-8	Ryan White Funded Performance Measures for 2016-2017
A-9	COOP Resource List
A-10	Virginia Ryan White Programs
A-11	Ryan White Part A and Part B Fundable Program Services
A-12	Ryan White Program Service Definitions
A-13	VDH Service Unit Definitions
A-14	Fee-for-Service Reimbursement for Outpatient Ambulatory HIV Medical Care – Policy & 2016 Fee Schedule
A-15	Assurances – Non Allowable Use of Ryan White Funds
A-16	Summary Table of Document Deliverables to VDH
A-17	ACA Enrollment Tracking Log of ADAP Client
A-18	Fuel/Gift Card Log
A-19	HIV Care Services – Subrecipient Guidelines Certificate of Receipt

Electronic copies of the templates in the Attachments are located on the HIV Care Services webpage at <http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/> and are available from your HIV Services Coordinator.

**FY 2016: Income Requirements by Federal Poverty Level (FPL)**

A-1

As the payer of last resort, Virginia’s Ryan White Part B Medical Care and Support Services & AIDS Drug Assistance Program (ADAP), provides medications, medical care and support services to people living with HIV/AIDS whose established income is 400% of the FPL or less.

FAMILY SIZE (# of people)	FPL (FY2016)	Care & Support or ADAP
		400% FPL
1	\$11,880	\$47,520
2	\$16,020	\$64,080
3	\$20,160	\$80,640
4	\$24,300	\$97,200
5	\$28,440	\$113,760
6	\$32,580	\$130,320
7	\$36,730	\$146,920
8	\$40,890	\$163,560
Each additional person	\$4,160	\$16,640

Effective April 1, 2016



**Virginia Department of Health**  
**Division of Disease Prevention**  
**Budget Line Item Format**

The following categories and format are being provided to ensure appropriate ordering of budget categories and placement of line items. The descriptions under each are examples of allowable costs but may not be approved or included in every contract. Specific line items and costs are negotiated in your initial contract with any modifications requiring approval. Refer to the HIV Care Services webpage, <http://www.vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/>, for VDH approved budget templates. Subrecipients are required to use these templates when submitting budgets for approval. If you have any questions, please contact your HIV Services Coordinator.

**Caps on Expenses:**

All Part B subrecipients can allocate up to 10% of their grant award for administration, planning, and evaluation. In accordance with HRSA Monitoring Standards, this now includes rent and utilities for medical facilities which in the past, used to be included in Direct Services. Subrecipients may choose to pass on a portion of the 10% to their subcontractors, but combined administration, planning and evaluation for subrecipients and their subcontractors cannot exceed 10 percent. VDH allows Consortia and selected subrecipients to allocate up to 5% of the total grant award for QM if approved by VDH.

Include the following in the Budget Justification narrative:

**Personnel Costs:**

Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percent of full time equivalency charged to RWB and annual salary. Other funding streams supporting remaining salary costs and the corresponding full time equivalency must also be identified.

**Indirect Costs:**

Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term “facilities and administration” is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS’s Division of Cost Allocation (DCA). Visit DCA’s website at: <https://rates.psc.gov/fms/dca/s%26l.html> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them. If you do not have documentation from a federal agency of your indirect rate negotiated in accordance set forth in the federal circular 2 CPR 220, you may not invoice for indirect costs. Instead you must budget your administrative costs by line item

**Fringe Benefits:**

List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement. The fringe

benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

**Travel:**

List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops. Travel for staff business must be made in the most cost effective way possible. Taxi fare for staff travel will not be reimbursed except for some situations concerning out of town travel (such as travel from an airport to a hotel). Justification for use of taxis out of town must be submitted with your invoice.

**Equipment:**

List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification of the need for the equipment and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of \$5000 and a useful life of one or more years). Extensive Justification will be defined in the Invoice Submission Guidelines issued under a separate cover.

**Supplies:**

List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, paper towels, toilet paper, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. They must be listed separately.

**Subcontracts:**

To the extent possible, all subcontract budgets and justifications should be standardized, and contract budgets should be presented by using the same object class categories contained in the Standard Form 424A. Provide a clear explanation of the purpose of each contract; how the costs were estimated, and the specific contract deliverables.

**Other:**

Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, grantee rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

**Start-up:**

Start-up funds are available for new contracts only. This does not include renewals. Startup funds should be requested at the time of contract negotiations. Once contracts have been signed by the DDP and VDH administration, the DDP will process start-up fund requests. Start-up funds may not exceed 1/12 of the total budget. Letters requesting start-up funds should be submitted along with the budget and work plan to the Division Director.

**PROGRAM:** \_\_\_\_\_  
**AGENCY:** \_\_\_\_\_  
**CONTRACT/MOA #:** \_\_\_\_\_  
**GRANT YEAR (specify start and end dates)** \_\_\_\_\_

	Direct Service	Administrative	QM (If Allowable)	Planning and Evaluation (If Allowable)	<b>TOTAL</b>
1. Personnel					
2. Fringe					
3. Travel					
4. Equipment					
5. Supplies					
6. Contractual					
7. Other					
8. Indirect					
9. Start Up					
<b>TOTALS</b>					
Projected Program Income					

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Definitions:**

**Direct Service** – Activities related to direct client service (i.e. personnel that work with clients and/or determine eligibility and those that directly supervise service provision).

**Administrative**– Activities related to operation of the agency, but not directly involved in client services (e.g. accountant, agency operations, and administrative staff).

**Planning and Evaluation** (if allowable) - Activities related to needs assessments, client satisfaction, evaluation of effectiveness of system operations, etc.

**Quality Management** (if allowable) – Activities related to assessing and improving quality of service through meeting and improving outcomes.

Virginia Department of Health (VDH), Office of Epidemiology  
**BUDGET REALLOCATION  
 REQUEST**

This form is to be used for zero sum budget adjustments only.

ORGANIZATION			
CONTRACT/MOA #			
BUDGET PERIOD			
GRANT PROGRAM			
<b>LINE ITEM</b>	<b>PREVIOUSLY APPROVED BUDGET</b>		<b>REQUESTED BUDGET REVISION</b>
PERSONNEL			
FRINGE			
TRAVEL			
EQUIPMENT			
SUPPLIES			
CONTRACTUAL			
OTHER (SPECIFY)			
INDIRECT			
<b>TOTAL</b>	\$	-	\$

**JUSTIFICATION:** (Attach new budget justification or additional information, as needed)

1. Reason why funds are available to be re-budgeted.

2. Proposed use for the re-budgeted funds.

**CERTIFICATION:** I certify that this re-budgeting is necessary to achieve project objectives, is consistent with the contract/MOA terms and conditions and VDH policies, represents effective utilization of resources, and does not constitute a change in scope.

**CONTRACTING AGENCY:**

Signature

Printed Name

Title

Date

**VDH APPROVAL:**

Contract Monitor Signature

Date

Program Manager Signature

Date

# Invoice Template

A-4

**Diana Jordan, Director**  
**Division of Disease Prevention**  
**P.O. Box 2448, Room 326**  
**Richmond, VA 23218**

**Indicate DDPP work unit in**

- Field Services
- HIV Care Services
- HIV Prevention Services
- HIV Surveillance
- Tuberculosis

**Date:** \_\_\_\_\_  
**Contract #:** \_\_\_\_\_  
**FIN:** \_\_\_\_\_  
**Program Name:** \_\_\_\_\_  
**Invoice Number:** \_\_\_\_\_

Dear Ms. Jordan:

In accordance with the contract between the Virginia Department of Health and \_\_\_\_\_ located at \_\_\_\_\_, I am requesting payment for services rendered during the time period \_\_\_\_\_ through \_\_\_\_\_ in the amount of \$ \_\_\_\_\_. Expenditures by approved budget line items are as follows:

Check here if new address

**EXPENDITURES**

Line Item	Approved Budget	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Total	Balance
Personnel															
Fringe															
Travel															
Equipment															
Supplies															
Contractual															
Other															
Admin															
<b>Total</b>															
Program Income Received															
Program Income Expenditures															
Program Income Balance		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

**I certify that this request for disbursement of funds has been reviewed by me and is accurate to the best of my knowledge and belief. The amounts itemized are considered to be legitimate and proper charges to the grant award indicated and are approved for payment. These charges have not been previously authorized or requested for payment. This certification applies to goods or services received or performed and travel expenses.**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**VDH USE: Use this check list before processing payment invoice**

Are the contract number and program name correct ?	
Are the contractor name and FIN correct ?	
Time period falls within contract period ?	
Line item budgets are current (i.e. modifications reflected)?	
Is the total budget amount correct ?	
Does each column add correctly ?	
Have startup funds been shown (if applicable) ?	
Do all prior payments match our records ?	
Does the YTD column match our records ?	
Has the request been signed by appropriate staff person ?	
Monitor made changes, initialed and notified contractor	

## **INSTRUCTIONS FOR COMPLETING SUBRECIPIENT REPORT NARRATIVES**

Monthly progress reports are an instrument for subrecipients to update the VDH, HCS Unit on the progress of the activities being carried out according to the agreement with VDH for the provision of Ryan White Core and Support Services. The monthly report should reflect accurate and complete information about the progress to goals outlined in the work plan of each subrecipient. Monthly reports are due 30 calendar days after the month ends. The instructions below will provide a clear explanation for each section of the document. Below is a detailed explanation for each section of the program report document. Please review all information carefully to ensure the correct information is being recorded.

### **Highlights:**

In this section, it is expected that subrecipients will highlight/ summarize activities being carried out as part of RWB services. Report any activities that impact the program. These impacts can be either positive or negative in nature. An example is: *Subrecipient X conducted a workshop for clients on the importance of stress management to reduce illness.*

### **Activities Undertaken to Meet Work Plan Objectives:**

In this section you will talk about the activities you have conducted during the reporting period to meet work plan objectives. You can also discuss any outcome objectives you have completed. This section should relate back to your work plan. Any other activities that are not related to your objectives should be reported in the highlight section. *For example, 12 clients received oral health services in the September. We have met our goal for the quarter of patients seen for services.*

### **Lead Agency Activities (for consortia only):**

In this section you will talk about the activities you have conducted during the reporting period to meet the above process objectives. Report on QM, and planning and evaluation activities in this section as it relates to the coordination of services for the consortium.

### **Quality Management:**

Report on the percentage of compliance with HRSA quality indicators by running the quality indicator report in e2Virginia. For subrecipients who are funded for medical case management (MCM), please also run the MCM quality indicator report in e2Virginia in addition to the quality indicator report. Subrecipients are also asked to report on the successes and challenges of their QM Plan and QIP. The subrecipient shall submit their QIP progress report on a quarterly basis (July, October, January, and April).

### **Medication Access:**

In this section please report all activities conducted to ensure clients have access to HIV-related medications. Report any barriers that have come up in providing this service to clients. Include activities conducted to assist in the enrollment or re-enrollment of clients into the ACA Health Insurance Marketplace and what educational activities took place to help clients use their insurance to receive covered services.

**Waitlist Status:**

In this section, report on any wait list in Ryan White Part B funded services. Discuss the wait time for first appointments and any change in an existing waitlist. A wait list is defined as a wait time of two weeks or more for an initial appointment. If no wait time exist but you are expecting one to occur please note the information in this section. Use this section to report waitlists for other non RWB funded services that are or could have an impact on a client's retention in care or positive health outcomes.

**Service Delivery Changes:**

In this section please discuss any changes to the services being delivered to clients. This includes information on additions, deletions, or changes in the initial contract and work plan. If there are personnel changes please discuss them in this section.

**Problems or Barriers:**

In this section, please discuss any barriers to care or problems encountered that have occurred in administering services. If there is a plan in place to address the barriers please discuss it.

**Technical Assistance:**

In this section, please discuss any technical assistance request the subrecipient has for VDH. In addition, please update the progress of existing technical assistance being provided. For Lead Agencies (Consortia) also discuss any technical assistance that has been provided to subcontractors or the progress of ongoing technical assistance to subcontractors.

**Expenditure Status:**

Use the expenditure and service table to record the actual expenses and services for the reporting period. In the first row record the month and percent of funding expended as of reporting period. This should reflect total percentage. In the services category column record the services that the subrecipient is funded to provide. Break services down by core medical and support services as defined by HRSA. In the first column under expenditures, record the approved budget for each service category. In the second column under expenditures record expenditures for the current reporting period only. In the third record the expenditures from beginning of the grant year to current reporting period. If not receiving administration or QM funding, enter 0. The balance will populate for the balance.

For service units, report the projected service units for each service category in the first column under service units. In the second column under service units report the current number of units for the reporting period. In the third column, report on the number of service units from the beginning of the grant year to the current reporting period. The percent to goal will calculate automatically. Report the information utilizing the number of unduplicated clients in the unduplicated client row. If unable to complete the table, please provide an explanation for not completing. In addition, please provide any recommendations to assist in tracking expenditures.

Report your spending trends and need for additional funds or reallocation of existing funds to other service categories to meet an increased demand for specific services. Discuss your ability to spend down the entire Ryan White Part B award or if you need to reduce the award amount

due to staff vacancies or over-estimation of service needs (should be determined 6-months into the grant period).

**Report on Data Entry:**

In this section, please report on the status of entering data into e2Virginia. Also discuss if there are any variances in the data reported in e2Virginia versus your internal tracking mechanism. If you have any issues with entering data please discuss those issues so they can be addressed.

**Data to Care Initiative:**

Discuss monthly activities related to the DtC initiative, any barriers encountered, number of clients located, additional training, or technical assistance needs.

**Patient Navigation:**

Only complete this section if you are funded for this activity.

**Minority AIDS Initiative:**

Only complete this section if you are funded for this activity.

**Troubleshoot Tips:**

- The form is an excel file. Please do not change any of the formulas in the excel spreadsheet. They have been designed to ensure accuracy.
- To start a new line within excel hit Alt + Enter within the cell.
- Use your instructions to assist with addressing all topic areas.
- Run your e2Virginia data on the day you complete the report to ensure a better match. Print the e2Virginia report and submit with your report so we are able to track any variances in data.
- For the QM Indicators please run report on a calendar year for a better reflection of data.

For more information or concerns about using the program report form, please contact your HIV Services Coordinator.

## Subrecipient Report Narrative Template

A-6

<b>Contract #</b>		<b>Ryan White Part B Subrecipient Report</b>
<b>Subrecipient Name:</b>		
<b>Report Month:</b>	<b>Fiscal Year: 2016-2017</b>	
<b>Highlights:</b> Give an overview of Ryan White activities for the reporting period.		
<b>Activities Undertaken to Meet Work Plan Objectives:</b> Provide information that describes the activities undertaken in the reporting period to accomplish work plan objectives (e.g. 5 clients received medical case management services. We have achieved 20% of the goal for this objective).		
<b>Quality Management:</b> Report on percentage of compliance with HRSA quality indicators using data from e2Virginia and any quality improvement activities implemented.		
1. Report on the status of your Quality Management Plan including any successes and challenges:		
2. Report on any quality improvement activities implemented including percentage of compliance with HRSA quality performance indicators using data from VACRS:		
3. Report on the status of your Quality Improvement Project (QIP) including status of implementation, successes, and challenges:		
<b>Note:</b> <i>On a quarterly basis (July, October, January and April), please submit your QIP quarterly report with your monthly reports.</i>		
<b>Medication Access:</b> Report all activities conducted to ensure clients have access to HIV-related medication including your efforts to help enroll or re-enroll clients into a Virginia ADAP approved ACA health insurance plan and to educate clients about the use of insurance to receive covered services.		

--

**Waitlist Status:** Please report any waitlist for Ryan White Part B (RWB) funded services, first appointments, and/or any changes in wait lists experienced. A waitlist is defined as a wait time of two weeks or more for an initial appointment. Use this section to report waitlists for other non-RWB funded services that may be impacting a client's ability to remain in care or to maintain positive health outcomes.

--

**Service Delivery Changes:** Please discuss any additions, deletion or other changes in service provisions, including personnel.

--

**Problems or Barriers Encountered:** Discuss any barriers to care encountered in the reporting month.

--

**Technical Assistance:** Please discuss any technical assistance needs the agency has for VDH.

--

**Expenditure Status:** In the table below, attempt to report expenditures for funded service categories for FY 2016. To calculate the expenditures utilize the budget submitted to VDH with contract. Based on data submitted to e2Virginia, complete the table below with each service category you are funded to conduct. Report your projected number of clients served and service units. Please report the actual number served and service units in the reporting month. If unable to complete the table, please provide an explanation for not completing the table.

As of:				% of funds expended:								
Service Category	2016-2017 Expenditures				2016-2017 Reported Service Units				2016-2017 Unduplicated Clts			
	Budget	Current	YTD	Balance	Projected	Current	YTD	% to goal	Projected	Current	YTD	% to goal
<b>Core Services</b>	\$0.00	\$0.00	\$0.00	\$0.00	0	0	0	#DIV/0!	0	0	0	#DIV/0!
				\$0.00				#DIV/0!				#DIV/0!
				\$0.00				#DIV/0!				#DIV/0!
<b>Support Services</b>	\$0.00	\$0.00	\$0.00	\$0.00	0	0	0	#DIV/0!	0	0	0	#DIV/0!
				\$0.00				#DIV/0!				#DIV/0!
				\$0.00				#DIV/0!				#DIV/0!
				\$0.00				#DIV/0!				#DIV/0!
				\$0.00				#DIV/0!				#DIV/0!
				\$0.00				#DIV/0!				#DIV/0!
<b>Subtotal Services:</b>	\$0.00	\$0.00	\$0.00	\$0.00	0	0	0	#DIV/0!	0	0	0	#DIV/0!
<b>Administration:</b>				\$0.00								
<b>QM:</b>				\$0.00								
<b>Total:</b>				\$0.00								

**Report on status of spending:** Are you on track with spending for the month and year? Do you anticipate requesting additional funds or having funds remaining at the end of the grant period? Do you need to reallocate funds to meet high demand for specific services? Please explain.

**Report on the status of e2Virginia data entry and any problems encountered in interfacing with the data system.**

**Please discuss any variances in projected numbers versus actual (e.g. may not meet or exceed service units or clients served).**

**Data to Care (DtC) Initiative:** Report status of Out of Care Client lists and any barriers that were identified and resolved while performing DtC activities. Indicate additional training or technical assistance needed.

**Patient Navigation:** For subrecipients performing this service, report any highlights challenges, solutions, and program accomplishments while implementing the Patient Navigation Strategy Protocol. Complete the Patient Navigation Services Summary Table for the reporting month.

**Patient Navigation Services Summary Table**

Activity	Projected	Monthly Total	YTD Total	% to Goal	Comments
# of CCSA Forms Received					
# of New Referrals into PN Program				#DIV/0!	
# of Unduplicated Clients Served				#DIV/0!	
# of Newly Diagnosed Clients Linked to Care				#DIV/0!	
# of Lost to Care or Re-engaged Clients Linked to Care				#DIV/0!	
# of Clients Discharged from PN Services				#DIV/0!	
# of FM Audio Tapes Submitted					



## QUALITY IMPROVEMENT PROJECT PROPOSAL AND REPORTING TEMPLATE

Facility:
Contact:
Title of the Project : HIV Treatment Adherence (Medication):
Current HIV Treatment Adherence Rate:

**Goal Statement:**

**Team Members:**

<b>PLAN</b>	<p>Here is where you could lay out your plan for improving your HIV Treatment Adherence rate including:</p> <ul style="list-style-type: none"> <li>• Will we convene a Quality Improvement Team?</li> <li>• How will we determine if this is a service delivery issue or a systems issue?</li> <li>• How will we report my data and to whom?</li> <li>• Who of us is responsible for doing what?</li> <li>• How are we including consumers in our process?</li> <li>• When will we do all this by?</li> <li>• Who do we need buy-in from to achieve this goal?</li> </ul>
<b>DO</b>	<p>In this section you could describe what change(s) you are going to make to improve your HIV Treatment Adherence rate including:</p> <ul style="list-style-type: none"> <li>• Are we changing a widget, a system, the way we document care? Define the change</li> <li>• How will we know if our change is working? Decide how you will evaluate your change.</li> <li>• Who will implement the change? Pick one provider and one set of patients; start small, think big and grow!</li> <li>• When will do these changes and evaluations? Set measurement goals and evaluation points.</li> </ul>
<b>STUDY</b>	<p>In this section you could flush out your evaluation methods and data sources including:</p> <ul style="list-style-type: none"> <li>• Where will our data come from?</li> <li>• When will we review our data, before the submission date or after?</li> <li>• Who will review our data, a Quality Improvement Team?</li> <li>• Who is responsible for compiling our data and presenting it?</li> <li>• What will we do if our project is working?</li> <li>• What will we do if our project isn't working?</li> </ul>
<b>ACT</b>	<p>In this section you could talk about what steps will come once the initial outcome data is reviewed including:</p> <ul style="list-style-type: none"> <li>• If our project is working, will we implement facility-wide?</li> <li>• Who do we need buy-in from to implement?</li> <li>• When are we going to act? What is our deadline for changing the way we do things?</li> </ul>

## RYAN WHITE FUNDED PERFORMANCE MEASURES FOR 2016-2017

The measures include monitoring the Care markers including CD4 test date, viral load test date, antiretroviral therapy prescription date, or HIV medical care visit date. We define a care marker as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date.

Medical Case Management Health outcome Indicator to be Measured	Numerator:	Denominator:
<b>Linkage to HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Case Management</b> services who had a care marker within 3 months (90 days) of HIV diagnosis	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Case Management</b> services with a new HIV diagnosis in 12-month measurement period
<b>Retention in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Case Management</b> services who had at least two care markers in a 12 month period that are at least 3 months apart	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Case Management</b> services with at least one care marker in the 12 month period
<b>Antiretroviral Therapy (ART) Among Persons in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Case Management</b> services who are prescribed ART in the 12-month measurement period	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Case Management</b> services who had at least one care marker in the 12-month measurement period
<b>Viral Load Suppression Among Persons in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Case Management</b> with a viral load <200 copies/mL at last test in the 12-month measurement period	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Case Management</b> services who had at least one care marker in the 12-month measurement period

**If you are funded to provide multiple Ryan White services:**

Please use the same measures above for all your individual funded services by updating the red marked areas to match with each specific service.

*Please see following examples:*

Outpatient Ambulatory Medical Care Health outcome Indicator to be Measured	Numerator:	Denominator:
<b>Linkage to HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Outpatient Ambulatory Medical Care services</b> who had a care marker within 3 months (90 days) of HIV diagnosis	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Outpatient Ambulatory Medical Care services</b> with a new HIV diagnosis in 12-month measurement period
<b>Retention in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Outpatient Ambulatory Medical Care services</b> who had at least two care markers in a 12 month period that are at least 3 months apart	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Outpatient Ambulatory Medical Care services</b> with at least one care marker in the 12 month period

<b>Antiretroviral Therapy (ART) Among Persons in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Outpatient Ambulatory Medical Care services</b> who are prescribed ART in the 12-month measurement period	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Outpatient Ambulatory Medical Care services</b> who had at least one care marker in the 12-month measurement period
<b>Viral Load Suppression Among Persons in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Outpatient Ambulatory Medical Care services</b> with a viral load <200 copies/mL at last test in the 12-month measurement period	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Outpatient Ambulatory Medical Care services</b> who had at least one care marker in the 12-month measurement period
<b>Medical Transportation Health outcome Indicator to be Measured</b>	<b>Numerator:</b>	<b>Denominator:</b>
<b>Linkage to HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Transportation services</b> who had a care marker within 3 months (90 days) of HIV diagnosis	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Transportation services</b> with a new HIV diagnosis in 12-month measurement period
<b>Retention in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Transportation services</b> who had at least two care markers in a 12 month period that are at least 3 months apart	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Transportation services</b> with at least one care marker in the 12 month period
<b>Antiretroviral Therapy (ART) Among Persons in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Transportation services</b> who are prescribed ART in the 12-month measurement period	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Transportation services</b> who had at least one care marker in the 12-month measurement period
<b>Viral Load Suppression Among Persons in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Transportation services</b> with a viral load <200 copies/mL at last test in the 12-month measurement period	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Medical Transportation services</b> who had at least one care marker in the 12-month measurement period
<b>Mental Health Services Health outcome Indicator to be Measured</b>	<b>Numerator:</b>	<b>Denominator:</b>
<b>Linkage to HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Mental Health Services</b> who had a care marker within 3 months (90 days) of HIV diagnosis	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Mental Health Services</b> with a new HIV diagnosis in 12-month measurement period
<b>Retention in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Mental Health Services</b> who had at least two care markers in a 12 month period that are at least 3 months apart	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Mental Health Services</b> with at least one care marker in the 12 month period

<b>Antiretroviral Therapy (ART) Among Persons in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Mental Health Services</b> who are prescribed ART in the 12-month measurement period	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Mental Health Services</b> who had at least one care marker in the 12-month measurement period
<b>Viral Load Suppression Among Persons in HIV Medical Care</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Mental Health Services</b> with a viral load <200 copies/mL at last test in the 12-month measurement period	Number of people enrolled in RW Part B-funded Program living with HIV and receiving <b>Mental Health Services</b> who had at least one care marker in the 12-month measurement period

*The only exception is about Oral Health Care Services*

<b>Oral Health Care Health outcome Indicator to be Measured</b>	<b>Numerator:</b>	<b>Denominator:</b>
<b>Oral Health Education Among Persons in Oral Health Care Services</b>	Number of people enrolled in RW Part B-funded Program living with HIV and receiving Oral Health education session at least once during the twelve month period.	Number of people enrolled in RW Part B-funded Program living with HIV and receiving Oral Health Care Services, regardless of age.

## COOP RESOURCE LIST

If you would like specific information about developing a COOP, these sites are good places to start:

ADAP Emergency Preparedness Guide  
[www.nastad.org](http://www.nastad.org)

American Medical Association Center for  
Public Health Preparedness and Disaster  
Response  
[www.ama-assn.org](http://www.ama-assn.org)

American Red Cross Disaster Services  
[www.redcross.org/services/disaster](http://www.redcross.org/services/disaster)  
[www.redcross.org](http://www.redcross.org)

Are You Ready? An In-depth Guide to  
Citizen Preparedness  
<http://www.ready.gov/are-you-ready-guide>

ASTHO  
[www.astho.org/](http://www.astho.org/)

Centers for Disease Control and Prevention  
Emergency Preparedness and Response  
[www.bt.cdc.gov](http://www.bt.cdc.gov)

Emergency Email and Wireless Network  
Notification System  
[www.emergencyemail.org](http://www.emergencyemail.org)

Emergency Management Assist Compact  
[www.emacweb.org](http://www.emacweb.org)

FEMA Risk Assessment Form  
<http://www.fema.gov/hazard-mitigation-planning-risk-assessment>

FEMA State Offices and Agencies of  
Emergency Management  
HRSA Emergency Planning  
<https://www.fema.gov/emergency-management-agencies>  
[www.hrsa.gov/emergency](http://www.hrsa.gov/emergency)

NACCHO  
[www.naccho.org/topics/emergency](http://www.naccho.org/topics/emergency)

Pandemic Flu  
<http://www.flu.gov>

Virginia Emergency Preparedness and  
Response  
<http://www.vdh.virginia.gov/EmergencyPreparednessResponse.htm>

**VIRGINIA RYAN WHITE PROGRAMS**

<b><u>Ryan White Part</u></b>	<b><u>Site</u></b>	<b><u>City</u></b>
<b>A</b> Metro Area	Norfolk Transitional Grant Area (TGA)	Norfolk
<b>A</b> Metro Area	Washington, DC Eligible Metropolitan Area (DC EMA)	Washington DC/Northern Virginia
<b>B</b> State	Virginia Department of Health	Richmond
<b>C</b> Early Intervention	Carilion Medical Center	Roanoke
<b>C</b> Early Intervention	Centra Health, Inc.	Lynchburg
<b>C</b> Early Intervention	Eastern Virginia Medical School	Norfolk
<b>C</b> Early Intervention	Inova Health System	Fairfax
<b>C</b> Early Intervention	Mary Washington Hospital/Medicorp Health System	Fredericksburg
<b>C</b> Early Intervention	University of Virginia	Charlottesville
<b>C</b> Early Intervention	Virginia Commonwealth University	Richmond
<b>D</b> Women, Infants, Children, Youth	Inova Health System	Fairfax
<b>D</b> Women, Infants, Children, Youth	University of Virginia	Charlottesville
<b>F</b> AIDS Education and Training Center Pennsylvania/Mid-Atlantic (AETC)	Virginia Commonwealth University	Richmond
	Inova Health System	Fairfax

**Ryan White HIV/AIDS Program Services List**

<b>Allowable Program Services</b>	
<b>Core Medical Services</b>	
<b>1.</b>	Outpatient /Ambulatory Health Services
<b>2.</b>	AIDS Drug Assistance Program Treatments (ADAP)
<b>3.</b>	AIDS Pharmaceutical Assistance
<b>4.</b>	Oral Health Care
<b>5.</b>	Early Intervention Services
<b>6.</b>	Health Insurance Premium & Cost Sharing Assistance for Low-Income Individuals
<b>7.</b>	Home Health Care
<b>8.</b>	Home and Community-Based Health Services
<b>9.</b>	Hospice Services
<b>10.</b>	Mental Health Services
<b>11.</b>	Medical Nutrition Therapy
<b>12.</b>	Medical Case Management, including Treatment Adherence
<b>13.</b>	Substance Abuse Outpatient Care
<b>Support Services</b>	
<b>14.</b>	Non-Medical Case Management Services
<b>15.</b>	Child Care Services
<b>16.</b>	Emergency Financial Assistance
<b>17.</b>	Food Bank/Home Delivered Meals
<b>18.</b>	Health Education/Risk Reduction
<b>19.</b>	Housing
<b>20.</b>	Legal Services (see Other Professional Services)
<b>21.</b>	Linguistics
<b>22.</b>	Medical Transportation
<b>23.</b>	Outreach Services
<b>24.</b>	Permanency Planning (see Other Professional Services)
<b>25.</b>	Psychosocial Support Services
<b>26.</b>	Referral for Health Care and Support Services
<b>27.</b>	Rehabilitation Services
<b>28.</b>	Respite care
<b>29.</b>	Substance Abuse Services (residential)
<b>30.</b>	Other Professional Services

## **RYAN WHITE PROGRAM SERVICE DEFINITIONS**

### **Grant Year 2017-2018**

The Ryan White Program Service Definitions were revised by HRSA/HAB in 2016 with an effective date of October 1, 2016. The revised service definitions below are included in *Policy Clarification Notice #16-02, Ryan White HIV/AIDS Program Services: Eligibility Individuals & Allowable Uses of Funds* available online at:

<http://www.vdh.virginia.gov/content/uploads/sites/10/2016/03/HAB-Service-Category-PCN-16-02.pdf>.

### **CORE SERVICES**

1) ***Outpatient/Ambulatory Health Services*** are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis Program

*Program Guidance:* Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

See [Policy Notice 13-04: Clarifications Regarding Clients Eligibility for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program](#)

*See Early Intervention Services*

- 2) ***AIDS Drug Assistance Program Treatments:*** The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the RWHAP to provide FDA-approved medications to low income clients with HIV disease who have no coverage or limited health care coverage. ADAPs may also use program funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy. RWHAP ADAP recipients must conduct a cost effectiveness analysis to ensure that purchasing health insurance is cost effective compared to the cost of medications in the aggregate. Eligible ADAP clients must be living with HIV and meet income and other eligibility criteria as established by the state.

*Program Guidance:*

See PCN 07-03: [The Use of Ryan White HIV/AIDS Program, Part B \(formerly Title II\), AIDS Drug Assistance Program \(ADAP\) Funds for Access, Adherence, and Monitoring Services](#);

PCN 13-05: [Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance](#); and

PCN 13-06: [Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid](#)

*See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance*

- 3) ***AIDS Pharmaceutical Assistance*** services fall into two categories, based on RWHAP Part funding.
1. Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or subrecipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

RWHAP Part A or B recipients using the LPAP service category must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board

- A drug formulary approved by the local advisory committee/board
  - A drug distribution system
  - A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum of every six months
  - Coordination with the state's RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state ADAP and the need for the LPAP
  - Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program
2. Community Pharmaceutical Assistance Program is provided by a RWHAP Part C or D recipient for the provision of long-term medication assistance to eligible clients in the absence of any other resources. The medication assistance must be greater than 90 days.

RWHAP Part C or D recipients using this service category must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV primary care medications not otherwise available to the client
- Implementation in accordance with the requirements of the 340B Drug Pricing Program and the Prime Vendor Program

*Program Guidance:* For LPAPs: Only RWHAP Part A grant award funds or Part B Base award funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP. For Community Pharmaceutical Assistance: This service category should be used when RWHAP Part C or D funding is expended to routinely refill medications. RWHAP Part C or D recipients should use the Outpatient Ambulatory Health Services or Emergency Financial Assistance service for non-routine, short-term medication assistance.

See [Ryan White HIV/AIDS Program Part A and B National Monitoring Standards](#)  
See also [LPAP Policy Clarification Memo](#)

*See also AIDS Drug Assistance Program Treatments and Emergency Financial Assistance*

- 4) **Oral Health Care** services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.
- 5) **Early Intervention Services (EIS): The RWHAP legislation defines EIS for Parts A, B, and C.** See § 2651(e) of the Public Health Service Act.
  - RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected
      - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
      - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis
  - RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
      - Recipients must coordinate these testing services under Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
      - The HIV testing services supported by Part C EIS funds cannot supplant testing efforts covered by other sources

- Referral and linkage to care of HIV-infected clients to Outpatient/ Ambulatory Health Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
- Other clinical and diagnostic services related to HIV diagnosis

*Program Guidance:* The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

6) ***Health Insurance Premium & Cost Sharing Assistance for Low-Income Individuals*** provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RWHAP funds for health insurance premium and cost sharing assistance, a RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- RWHAP Part recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services
- RWHAP Part recipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective

The service provision consists of either or both of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients
- Paying cost-sharing on behalf of the client

*Program Guidance:* Traditionally, RWHAP Parts A and B funding support health insurance premiums and cost-sharing assistance. If a RWHAP Part C or D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective and sustainable.

See PCN 07-05: [Program Part B ADAP Funds to Purchase Health Insurance;](#)

PCN 13-05: [Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance;](#)

PCN 13-06: [Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid;](#) and

PCN 14-01: [Revised 4/3/2015: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act](#)

7) **Home Health Care** is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
- Other medical therapies

*Program Guidance:* The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

8) **Home and Community-Based Health Services** are provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

*Program Guidance:* Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

9) **Hospice Services** are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

*Program Guidance:* Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes. To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

10) **Mental Health Services** are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

*Program Guidance:* Mental Health Services are allowable only for HIV-infected clients.

11) **Medical Nutrition Therapy** includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

*Program Guidance:* All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

*See Food-Bank/Home Delivered Meals*

12) ***Medical Case Management, including Treatment Adherence Services*** is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- 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 treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

*Program Guidance:* Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have

as their objective providing guidance and assistance in improving access to needed services.

13) ***Substance Abuse Outpatient Care*** is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals o Relapse prevention
  - Relapse prevention

*Program Guidance:* Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan. Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific guidance.

*See Substance Abuse Services (residential)*

## **SUPPORT SERVICES**

14) ***Non-Medical Case Management Services (NMCM)*** provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category

includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

*Program Guidance:* Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

15) ***Child Care Services*** support intermittent child care services for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions. Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care  
HIV/AIDS BUREAU POLICY 16-02 16
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

*Program Guidance:* The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted. Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process. **NOTE: This does not include child care while a client is at work.**

16) ***Emergency Financial Assistance*** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

*Program Guidance:* Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

*See AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance, and other corresponding categories*

17) **Food Bank/Home Delivered Meals** refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist.

*Program Guidance:* Unallowable costs include household appliances, pet foods, and other non-essential products.

*See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the RWHAP.*

18) **Health Education/Risk Reduction** is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

*Program Guidance:* Health Education/Risk Reduction services cannot be delivered anonymously.

*See Early Intervention Services*

- 19) **Housing** services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services. Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation. Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

*Program Guidance:* RWHAP Part recipients must have mechanisms in place to allow newly identified clients access to housing services. Upon request, RWHAP recipients must provide HAB with an individualized written housing plan, consistent with RWHAP Housing Policy 11-01, covering each client receiving short term, transitional and emergency housing services. RWHAP recipients 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. The US Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients consider using HUD's definition as their standard. Housing services funds cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

*See PCN 11-01 [The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-term or Emergency Housing Needs](#)*

- 20) **Legal Services** (*see Other Professional Services*)

- 21) **Linguistics** services provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.

*Program Guidance:* Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

22) **Medical Transportation** is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

*Program Guidance:* Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

23) **Outreach Services** include the provision of the following three activities:

- Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
- Provision of additional information and education on health care coverage options
- Reengagement of people who know their status into Outpatient/Ambulatory Health Services

*Program Guidance:* Outreach programs must be:

- Conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior

- Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness
- Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort
- Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection Funds may not be used to pay for HIV counseling or testing under this service category

Funds may not be used to pay for HIV counseling or testing under this service category. See [Policy Notice 12-01: The Use of Ryan White HIV/AIDS Program Funds for Outreach Services](#). Outreach services cannot be delivered anonymously as personally identifiable information is needed from clients for program reporting.

*See Early Intervention Services*

24) ***Permanency Planning (see Other Professional Services)***

25) ***Psychosocial Support Services*** provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Caregiver/respite support (RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
- Pastoral care/counseling services

*Program Guidance:* Funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home Delivered Meals). RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation. Funds may not be used for social/recreational activities or to pay for a client's gym membership. For RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be

reported as Psychosocial Support Services; this is generally only a permissible expense under RWHAP Part D.

*See Respite Care Services*

- 26) **Referral for Health Care and Support Services** directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to 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 Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

*Program Guidance:* Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category. Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

- 27) **Rehabilitation Services** are provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care.

*Program Guidance:* Examples of allowable services under this category are physical and occupational therapy.

- 28) **Respite Care** is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

*Program Guidance:* Recreational and social activities are allowable program activities as part of a respite care service provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities. Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership. Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

*See Psychosocial Support Services*

- 29) **Substance Abuse Services (residential)** is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

*Program Guidance:* Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the RWHAP. Substance abuse services (residential) are not allowable services under RWHAP Parts C and D. Acupuncture therapy may be allowable funded under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the RWHAP. RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

30) ***Other Professional Services*** allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
  - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
  - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP
  - Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney

- Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits

*Program Guidance:* Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

## VDH Service Unit Definitions

Fiscal Year 2016-2017	
HRSA Service Categories	Service Unit Definition (each definition in this column constitutes 1 unit)
<b>1. Core Medical Services</b>	
a. Outpatient /Ambulatory Health Services	One medical prescribing provider office visit per day per physician/group practice for uninsured client *
a1. Laboratory Test	One individual lab test (e.g. a panel of five lab tests = 5 units) for uninsured client
d. Oral Health Care	One visit for uninsured client <b>OR</b> one oral health visit copayment or cost share for insured client
f. Health Insurance Premium & Cost Sharing Assistance	One medical office visit or lab copayment or cost share for insured client
j. Mental Health Services	One mental health provider visit per day* for uninsured client <b>OR</b> one mental health office visit copayment or cost share for insured client
k. Medical Nutrition Therapy	One case of medical nutritional supplement or one visit with registered dietician
l. Medical Case Management (including Treatment Adherence)	A 15 minute encounter with case manager (e.g. 1 hour = 4 units)
m. Substance Abuse Services—outpatient	One substance abuse provider visit per day for uninsured client* <b>OR</b> one substance abuse office visit copayment or cost share for insured client

2. Support Services	
n. Case Management (non-Medical)	A 15 minute encounter with case manager (e.g. 1 hour = 4 units)
q. Emergency Financial Assistance	Payment for one 30-day or less prescription for Ryan White Part B non-ADAP formulary medication for uninsured client <sup>1</sup> <b>OR</b> one food voucher
r. Food Bank/Home-Delivered Meals	One bag of food, voucher to food pantry, or delivered meal, one case of nutritional supplement**
s. Health Education / Risk Reduction	One 15 minute encounter
v. Linguistic Services	One provided linguistic service***
w. Medical Transportation Services	A one way trip = 1 unit; One voucher = 1 unit
x. Outreach Services	One 15 minute outreach encounter

\*An additional visit on the same date of service at a different practice/site = one unit. All categories assume one or more client encounters per day with the same practice/site = one unit.

\*\* In accordance the provision of Medical Nutritional Therapy must be conducted by a registered dietitian. Issuing nutritional supplements without a dietician falls under food bank and home delivered meals.

\*\*\* Linguistic services include verbal or written translation for a client to assist with language barriers.

<sup>1</sup> Refer to the Virginia Department of Health, Ryan White Part B Non-ADAP Formulary located at <http://www.vdh.virginia.gov/disease-prevention/formulary/>.

**Virginia Department of Health, Division of Disease Prevention**  
**HIV Care Services**

**POLICY ON FEE-FOR-SERVICE REIMBURSEMENT FOR OUTPATIENT  
AMBULATORY HIV MEDICAL CARE**

**BACKGROUND:**

The Virginia Department of Health (VDH), Division of Disease Prevention, HIV Care Services Unit, is implementing a fee-for-service payment process for outpatient ambulatory HIV medical care office visits reimbursed to service subrecipients. Fee-for-service is defined as a system of payment for professional services in which the practitioner is paid for a service rendered, rather than receiving salary and benefit reimbursement.

The established reimbursement rates are based on Virginia non-facility 2016 Medicare rates. The rates are located on the Centers for Medicare and Medicaid Services CMS.gov website located at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html>.

An allowable reimbursement fee-for-service rate is associated with a code that has an established definition with key components including complexity, severity, and time spent face-to-face. The Current Procedural Terminology (CPT) code set maintained by the American Medical Association through the CPT Editorial Panel has been used as a reference for the Virginia RWB code set to provide similarity to other billing activities of providers. The description of the CPT codes can be found on the American Medical Association website located at <https://ocm.ama-assn.org/OCM/CPTRelativeValueSearch.do>.

**POLICY:**

Effective April 1, 2014, reimbursement for contracted outpatient ambulatory HIV medical care office visits will be under a fee-for-service rate.

Fee-for-service reimbursement is only made for service provision to uninsured clients. Fees will be reimbursed according to comparable CPT coding maintained by the American Medical Association through the CPT Editorial Panel. The allowable office visit codes that can be utilized are: 99201-99205 for new clients or 99211-99215 for established clients.

Specific office visit codes and rates are set by VDH. Any claims submitted for a higher rate will not be accepted. Subrecipients may negotiate a lower reimbursement fee.

Total amount of funding available to a subrecipient for medical services is set through contractual terms. Requests for payment that exceed the contracted amount will not be reimbursed.

## **REVIEW OF FEE SCHEDULE:**

VDH will review reimbursement rates and coding definitions annually. The Virginia RWB Fee-For-Service 2016 Rate Schedule is attached.

## **DOCUMENTATION:**

Subrecipients must submit the following information for reimbursement:

- Provider information including provider name, address, phone number, and federal tax identification number
- Patient information including complete name, address, date of birth, and telephone number
- Patient Ryan White I.D. Number
- Date of Service
- Virginia Ryan White Fee-for-Service Code (CPT Code)
- Virginia Ryan White Fee-for-Service Reimbursement Rate requested

Subrecipients may submit a completed standard claim form CMS-1500 including the information above, or in a format approved by VDH, as supporting documentation for each uninsured client visit with monthly invoices in order to receive reimbursement. One CMS-1500 form or comparable data set must be submitted for each visit per client, serving as the source documentation that will be used for office visit reimbursement.

## **GUIDANCE:**

VDH does not operate as an “insurer”, but reimburses costs through contractual terms. Some agencies have reported that use of the CMS-1500 form may create confusion with fiscal and reimbursement departments who may believe insurance is being billed. Decisions about using a CMS-1500 form versus a comparable data set should be made in collaboration with affected agency departments.

## **EXCEPTION:**

Any request for exception to this policy or policy requirements must be submitted in writing to:

Kimberly A. Scott, M.S.P.H.  
Acting Director, HIV Services  
Division of Disease Prevention  
Virginia Department of Health  
P.O. Box 2448, Room 326  
Richmond, VA 23218-2448

**Virginia Ryan White Part B Fee-For-Service Rate Schedule (2016)**

Code	Description	Ryan White Part B Fee
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	\$43.30
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	\$74.02
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	107.21
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	\$163.51
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	\$205.12
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	\$19.76
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	\$43.00
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	\$72.34
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	\$106.63
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	\$143.68

Assurances  
Non Allowable Use of Ryan White Funds

Below is a list of all non-allowable uses of Ryan White Funding. Subrecipients and subcontractors please sign and date this list assuring VDH that no Ryan White funds will be used to either purchase the following items or engage in the following activities.

**Unallowable Purchases:**

- Clothing
- Gift cards with a VISA, Master Card, Discover, American Express or other credit card logo
- Funeral, burial, cremation or related expenses
- Local or state personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied)
- Household appliances
- Pet foods or other non-essential products
- Off-premise social/recreational activities or payments for 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
- Inpatient hospital services, or nursing home or other long-term care facilities
- Purchase vehicles
- Foreign Travel
- Cost 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 the Social Security Act

**Unallowable Activities:**

- \*Use of funds for cash payments to service recipients.
- Develop materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual.
- Non-targeted marketing promotions or advertising about HIV services that target the 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, outreach activities that have HIV prevention education as their exclusive purpose.
- Influencing or attempting to influence members of Congress and other Federal personnel.

\*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.

\_\_\_\_\_  
Name of Organization

\_\_\_\_\_  
Subrecipient Signature and Title

\_\_\_\_\_  
Subrecipient Print Name

\_\_\_\_\_  
Date

## Summary Table of Document Deliverables to VDH

Below is a table that details the documents, frequency and due dates for submission to VDH. If you have questions about their applicability to your organization, please check with your HIV Services Coordinator. In addition to submitting these documents, attendance is also required at the Quarterly Subrecipients Meeting, Quality Management Advisory Committee Meetings, the Quality Management Summit, meetings and updates related to VDH's client-level data system, and other meetings or trainings that may be specific to activities for which you are funded.

Document	Frequency	Due Date (s)
Certification Regarding Lobbying * (signed)	Annually	Within 30 days from the beginning of the grant year
Disclosure of Lobbying (signed)	Annually	Within 30 days from the beginning of the grant year
Copy of Most Recent Audit to include Response and Corrective Action Plan **	Annually	Within 30 days from the beginning of the grant year
DDP Security and Confidentiality Guidelines ***	Annually for all employees that handle or have access to Personal Health Information	Within 30 days from the beginning of the grant year
Signed Assurances/Allowable Costs	Annually	July 1 <sup>st</sup> of each grant year
Copies of any Subcontracts (signed)	Annually	Within 30 days from the beginning of the grant year
Copy of Agency's Client Grievance Policy	Annually	Within 30 days from the beginning of the grant year
Copy of Agency's Administrative Allocation Cost Plan	Annually	Within 30 days from the beginning of the grant year ( <i>these also should be available during budget negotiations for the next grant period</i> )
Annual Report (Narrative)	Annually	45 days after the end of the grant year; submit with the final invoice
Final Reconciliation Invoice	Annually	45 days after the end of the grant year
Quality Management Plan	Annually	Within 60 days from the beginning of the Grant Year
Quality Improvement Project (QIP) Plan including baseline Data	Annually	Within 60 days from beginning of the grant year
Budgets and Expenditures from all Ryan White Parts	Annually	Annually
Data to Care (DtC) Lists and any other required documentation	As described in DtC Protocol	As described in DtC protocol
Patient Navigation (PN) Implementation Fidelity Summary Form and any other required documentation	Twice Annually	As described in PN protocol
Quality Improvement Project Report	Quarterly	1 <sup>st</sup> Quarter July 1 2 <sup>nd</sup> Quarter October 1 3 <sup>rd</sup> Quarter January 1 4 <sup>th</sup> Quarter April 1

Invoices, including reporting of program income	Monthly	Within 30 days following the month being invoiced
Monthly Progress Reports (Narrative) to include information on Quality Management and Quality Improvement Activities	Monthly	Within 30 days following the month being invoiced
Enter provider and client level data into VDH state-wide database	Monthly	Within 15 days following the end of the reported month
ADAP Client ACA Enrollment Tracking Log	Weekly	During ACA Health Insurance Marketplace Open Enrollment

- \* For contracts awards equal to or greater than \$100,000
- \*\* If an audit occurs during the contract period, submit a copy of the audit and response to VDH within 15 days of responding to the federal auditor.
- \*\*\*Submit the most recent version. Updates are posted in May of each year. For employees that are hired after July 1, but during the grant year, please submit a signed copy within 30 days of hire.

## ACA Enrollment Tracking Log of ADAP clients

Agency Name: \_\_\_\_\_

Client Last Name	Client First Name	Client DOB	Enrollment Date	Insurance Plan/Carrier	Enrollment Agency	Agency Contact Person	Agency Contact Person Email	Agency Contact Person Phone #	Comments



# HIV CARE SERVICES SUBRECIPIENT GUIDELINES 2016

## Certificate of Receipt



Your signature below indicates your receipt of the Virginia Department of Health, Division of Disease Prevention, HIV Care Services *SUBRECIPIENT GUIDELINES*.

Your signature does not imply agreement or disagreement with the guidelines; however, all subrecipients and their subcontractors are required to comply with these guidelines.

NAME  
(Print): \_\_\_\_\_ AGENCY: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_