RYAN WHITE PART A SERVICES REQUEST FOR PROPOSAL

FY 2025

Core Services	Support Services
AIDS Drug Assistance Program- (ADAP)	Emergency Financial Assistance- (EFA)
Medical Case Management- (MCM)	Food Bank/Home Delivered Meals- (FBHDM)
Medical Nutrition Therapy- (MNT)	Housing- (HOUS)
Oral Health Care-(OHC)	Linguistic Services- (LS)
	Medical Transportation- (MT)
	Non-Medical Case Management- (NMCM)
	Other Professional Services Legal- (OPS)
	Psychosocial Support Services- (PSS)

Minority AIDS Initiative (MAI) Services
Emergency Financial Assistance- (EFA)
Medical Case Management- (MCM)
Non-Medical Case Management- (NMCM)
Psychosocial Support Services- (PSS)
Other Professional Services Legal- (OPS)

Section I:
Ryan White Services
Boston Public Health Commission
1010 Massachusetts Avenue, 2nd Floor Boston,
MA 02118
Narrative, Overview, and Attachments

RFP Documents can also be found by visiting:
https://www.boston.gov/bid-listings

IMPORTANT DATES

October 18	**RFP Available** RFP Documents will be available online. The packet will be sent via RFP listserv, via the Ryan White Services Mailchimp, and will be posted on the Boston Public Health Commission's Open Bid website page and posted within the Boston Globe. *The RFP will NOT be mailed to any applicants.*
October 17 **October 24** **October 29** *More dates to come**	**RFP Bidders Conference*** The RFP Conference for all potential applicants will be held online via Zoom. Zoom links were announced and distributed several weeks in advance. BPHC staff will review the RFP document and answer questions. It is **required** to **attend one conference** during the proposal process. During the registration process, there will be a field to ask any questions pertaining to the RFP. Any questions submitted in other platforms are not guaranteed to be addressed. The RFP Conference will be conducted in English. BPHC will give technical assistance to applicants in other languages by request. The RFP document will be available online in MS Word-compatible format.
Friday, December 13, 2024	**Deadline for RFP Submission** Proposals are due via **email** by **5:00 PM, December 13, 2024** to the Boston Public Health Commission's Procurement Office rfr@bphc.org and cc ryanwhiteservices@bphc.org . ***There are no exceptions to this deadline.*** The narrative, budgets, and tables must be in the format provided and submitted in PDF. Please submit an additional copy of the budget(s) in Excel format. The responsibility for submitting a response to this RFP to the Ryan White Services team on or before the stated time and date will be the sole responsibility of the applicant.
November- January 2025	**Review Period** Proposals will be reviewed and evaluated using an independent evaluation process.
Wednesday, January 15, 2025	**Funding Announcement** Letters will be mailed to all applicants regarding the status of their funding/application status. BPHC has the discretion to extend this period without notice to the proposers. All proposals shall remain valid and open for a period of one hundred twenty (120) days from the proposal submission date unless a proposer notifies BPHC of its withdrawal.
March 1, 2025, – February 29, 2028	**Contract Period** The contract period is for the full grant period (3 years). All contracts will be written with the possibility of a continued extension beyond FY27, subject to the availability of funding.

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INTRODUCTION

The purpose of the Ryan White Part A program in the Boston Eligible Metropolitan Area (EMA) is to provide accessible, barrier-free services to eligible consumers. These services are intended to promote positive health outcomes, and self-sufficiency, and improve the quality of life for People Living with HIV/AIDS (PLWHA). The Boston Public Health Commission (BPHC), as the Recipient of Part A funding from the Health Resources Service Administration (HRSA), administers the funds in communities with high rates of HIV infection. Factors in these communities, including social determinants of health such as housing stability, food insecurity, and much more, can increase a person's risk of becoming infected with or affected by HIV. No single service is intended to meet a client's holistic needs; however, Part A services support work in tandem with core medical services to address the myriad socioeconomic barriers and inequity that often result in poor health outcomes. Addressing these barriers and inequities is also intended to prevent ongoing transmission of HIV infection within vulnerable populations.

BPHC has a long-established mission to invest in and contribute to efforts in our communities that promote health equity. This vision is exemplified in the administration of the Part A grant in the Boston EMA. The disproportionate burden of HIV and other infectious diseases on vulnerable populations dictates that Part A services prioritize the care of those most affected by the epidemic and assist those to achieve HIV viral suppression.

To ensure Ryan White HIV/AIDS Program (RWHAP) Part A Services are aligned with the needs of those who are disproportionately affected by HIV, the Ryan White Services Division (RWS), in collaboration with the Ryan White Planning Council and state entities, conducts ongoing needs assessments and collects community and subrecipients feedback to identify emerging needs in the Boston EMA. The information gathered is crucial to identifying gaps in the service delivery system and plays a vital role in the setting of priorities and allocation of Part A-funded services.

The previous service category portfolio in the Boston EMA funded ***thirteen*** service categories. This cycle the team will fund ***twelve*** service categories due to the removal of Health Education Risk Reduction. The available Core Medical Services included AIDS Drug Assistance Program, Medical Case Management, Medical Nutrition Therapy, and Oral Health Care. Support Services included Housing, Psychosocial Support Services, Emergency Financial Assistance, Food Bank Home Delivered Meals, Linguistics Services, Medical Transportation, Non-Medical Case Management and Other Professional Services Legal.

BPHC intends to administer Part A funds in accordance with Ryan White Legislation and HRSA policies to ensure quality services are delivered and are accessible to all eligible PLWHA.

REQUEST FOR PROPOSAL OVERVIEW

Through this Request for Proposals (RFP), the Boston Public Health Commission (BPHC) seeks proposals to provide Ryan White Part A Core Medical and Support services that target people living with HIV/AIDS (PLWHA) within the Boston Eligible Metropolitan Area (EMA) (*map, Appendix A*). The goals of these services are to (1) support individuals living with HIV to enter and remain in primary health care and health-related support services and (2) help improve the clinical health outcomes and quality of life of PLWHA.

All applicants applying for Ryan White Part A funds must adhere to the following HRSA mandates:

- Part A funds may not be used to supplant or replace current State or local HIV-related funding.
- Part A funds are intended to be administered as the payer of last resort; all subrecipients of Part A funds are expected to demonstrate that there are no other reasonable means to cover the cost of services billed to Part A.
- Part A funds may not be used to purchase or improve land, or to purchase, construct, or make permanent improvements to any building except for minor remodeling.
- Part A Funds may not be used to make payments to recipients of services.

Applicants wishing to apply for multiple service categories may submit <u>one proposal</u> with additional sections for each service category.

BPHC seeks applications from subrecipients that will be successful in engaging clients who know their HIV status but are not presently in care and assisting them in engaging in and maintaining access to the **HIV Care Continuum** (*HCC, Appendix C*). Services must conform to Health Resources and Services Administration (HRSA) definition(s) and any relevant HRSA and BPHC policies. BPHC intends to fund a group of subrecipients serving populations that are reflective of the **epidemiological profile** of the EMA (*Appendix B*).

This RFP is organized to assist you in navigating the application process. Section I outlines the goals and objectives for the upcoming contract period. In addition, it details basic eligibility information and the reporting and fiscal requirements that will be expected from Subrecipients should they be funded.

Section II contains the proposal preparation instructions, a checklist of required materials, a cover page, and the application questions. Attachments include business forms and copies of legal and financial forms to be completed if successfully funded.

RFP PROCESS

The Boston Public Health Commission (BPHC) is responsible for all RFP operations including producing the RFP, communications with applicant subrecipients, conducting an independent review of proposals, issuing contracts to awarded subrecipients, monitoring all funded programs, and developing evaluation standards and reports to assess the Ryan White Program's impact on the system of HIV services.

The RFP will be released to any potential applicants online at the RFP bidding website. The RFP will be sent via the newsletter and posted in the Boston Globe. The RFP Conferences will be held one week following the release of the RFP to review the document and to answer any questions from potential applicants. Following the RFP Conferences, BPHC staff will not communicate with any potential applicant regarding the service category content of the RFP.

All service contracts awarded by the Boston Public Health Commission may be subject to following the City of Boston's living wage ordinance. This ordinance requires that all employees working on sizable city contracts earn an hourly wage that is enough for a family of four to live at or above the federal poverty level. This wage amount called the living wage, is recalculated every year. For more information, please visit https://www.boston.gov/worker-empowerment/living-wage-division.

As part of BPHC's efforts to have an equitable procurement process, BPHC will consider and encourage Certified Unrepresentative Businesses Enterprises (CUBE) that include; Minority-owned Business Enterprises (MBE), Women-owned Business Enterprises (WBE), Veteran-owned Business Enterprises (VBE), Disability-owned Business Enterprise (DOBE), Lesbian Gay Bisexual Transgender Business Enterprises (LGBTBE), Minority Non-Profit (MNPO), Women Non Profit(WNPO), Minority Women Non Profit(MWNPO) and local businesses to apply to this RFP.

The funding cycle for programs funded under this RFP will be three (3) years March 1, 2025 – February 29, 2028 (FY 2025 – FY 2027). The first year of funding under this procurement will be for 12 months. All contracts will be written with the possibility of continued annual extension that is subject to performance, federal appropriations, and local allocations.

To be eligible for continued funding, all programs must be in **full program and fiscal compliance.** Programs will be reviewed for performance in relation to the contracted goals and objectives, which will be stipulated in the FY 2025 contract. Compliance is defined as:

- History of meeting program measures as outlined in the Provider Manual and Service Standards.
- History of spending the contract completing each cycle, and on allowable costs.
- History of timely invoice submission.
- History of timely and accurate data entry for each funded service category.

OVERVIEW OF THE RYAN WHITE PROGRAM

LEGISLATIVE BACKGROUND

Funds from Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (formerly Ryan White HIV/AIDS Treatment Modernization Act of 2006) provide direct financial assistance to Eligible Metropolitan Areas (EMA) and Transitional Grant Areas (TGA) that have been the most severely affected by the HIV epidemic. Formula (based on the number of HIV cases) and supplemental (based on grant performance) funding are intended to develop or enhance access to a comprehensive continuum of high-quality, community-based care for income-eligible individuals and families infected and affected by HIV disease.

The Part A Minority AIDS Initiative (MAI) originated in fiscal year (FY) 1998 when the U.S. Congress directed that a portion of the Part A supplemental appropriation be used to address growing disparities in access to care and health outcomes among minority populations disproportionately impacted by the HIV epidemic.

NATIONAL HIV/AIDS STRATEGY (NHAS)

In 2010, the White House released the first NHAS designed with four primary goals: 1) to reduce the number of new HIV infections; 2) to increase access to care and optimize health outcomes for persons living with HIV (PLWHA); 3) to reduce HIV-related health disparities and health inequities; and 4) to achieve a more coordinated national response to the HIV epidemic. This comprehensive strategy has guided how HIV prevention and care services are prioritized, organized, and provided across the country.

President Obama updated the NHAS in July 2015 to reflect lessons learned and looks ahead to 2020. Maintaining the original four goals, the NHAS Updated in 2022[1] highlights the need to address three priority activities:

- Widespread HIV testing and linkage to care enabling PLWHA to access treatment early.
- Broad support for PLWHA to remain engaged in comprehensive care, including support for treatment adherence.
- Universal viral suppression which has demonstrated overall health benefits and reduces viral transmission to others.

The 2022 NHAS includes 78 strategies for stakeholders to implement to achieve the four primary goals. Program activities should strive to support the primary goals of the 2022 NHAS and should further seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities.

For more information regarding the National HIV/AIDS Strategy, see https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025

[1]The White House. 2021. National HIV/AIDS Strategy for the United States 2022–2025. Washington, DC.

COMPREHENSIVE CARE CONTINUUM

A comprehensive continuum of care includes primary *Core Medical Care* for the treatment of HIV consistent with Public Health Service guidelines. Such care must include access to antiretrovirals and other drug therapies, including prophylaxis for and treatment of opportunistic infections as well as

combination antiretroviral therapies. Comprehensive HIV care also must include access to substance-abuse treatment, mental health treatment, oral health, and home health or hospice services. This continuum of care must also include *Support Services* that enable individuals to access and remain in primary medical care as well as services that promote health and enhance quality of life.

Comprehensive service delivery is accomplished through improved coordination and linkage of services and is designed to address the needs of PLWHA who know their status but are not in medical care. Providers are therefore required to establish formal relationships with a range of key points of entry into the system. These include but are not limited to:

- Emergency rooms,
- Substance abuse treatment programs,
- Detoxification programs,
- Adult and juvenile detention facilities,
- STD clinics,
- Federally qualified health centers,
- HIV disease counseling and testing sites,
- Mental health programs, and
- Homeless shelters.

The HIV Care Continuum (HCC, *Appendix C*), also known as the HIV treatment cascade, reflects the stages of HIV medical care through which PLWHA progresses from initial HIV diagnosis to viral suppression. Active surveillance regarding incidence and prevalence rates of HIV infection, treatment efforts, and viral suppression rates, allows public health to track progression toward reaching our National goals, measure the success of local efforts, and identify gaps for targeting additional efforts.

RECIPIENT AND PLANNING COUNCIL RESPONSIBILITIES

The Boston Eligible Metropolitan Area (EMA) service region defines seven counties in Massachusetts: Bristol, Essex, Middlesex, Plymouth, Norfolk, Suffolk, and Worcester; and three counties in southern New Hampshire: Hillsborough, Rockingham, and Strafford (*Appendix A*).

Part A grants are awarded to each EMA's Chief Elected Official (CEO). For the Boston EMA, the CEO is the Mayor of Boston, Michelle Wu. As the CEO, Michelle Wu is responsible for designating a Recipient and appointing the Boston EMA Ryan White Part A Planning Council.

The Boston Public Health Commission (BPHC) has been appointed Recipient for the Boston EMA responsible for administering the Part A grant as well as the following activities:

- Submitting a proposal to the Health Resources and Services Administration (HRSA) for the Part A award;
- Developing a request for proposals (RFP) for RW Part A funded HIV services within the EMA;
- Developing and implementing a proposal review process;
- Granting awards to programs for RW Part A funded HIV services;
- Writing and monitoring contracts for RW Part A funded HIV services;
- Developing Quality Improvement plans and providing technical assistance;
- Collecting and reporting data; and
- Evaluating the performance of funded subrecipients.

The Boston EMA Ryan White Part A Planning Council (Planning Council) is the local community planning body that directs the Recipient in its planning and resource allocation processes for Ryan White Part A funds. The Planning Council also works with the CEO (or his/her designee) and the Recipient to develop a plan for comprehensive services for PLWHA and their families within the EMA. A full overview of the Planning Council's responsibilities can be viewed at: http://www.bphc.org/whatwedo/infectious-diseases/Ryan- White-Services-Division/boston-planning-council/Pages/Boston-Planning-Council.aspx.

BOSTON EMA EPIDEMIOLOGICAL PROFILE

One of the objectives of Ryan White Part A is to deliver treatment and services to a client base reflective of the local epidemic with a strong focus on populations that have historically been underserved. Please refer to the demographics tables in *Appendix B* when describing client populations.

Target populations for all Core and Support Services

The target population for this RFP is all PLWHA residing within the ten-county region of the Boston EMA and who meet the BPHC HIV/AIDS guidelines that are based on a threshold of 500% of the current Federal Poverty Level (FPL) as determined by the U.S. Department of Health and Human Services (HHS), with an additional allowance for dependents based on the MassHealth dependent allowance. For more information regarding the 2024 Poverty Guidelines for the EMA, see: https://www.mass.gov/files/documents/2024/02/14/fpl-deskguide.pdf

Target populations for Minority AIDS Initiative (MAI) Services

Ryan White legislation designates MAI funding for services that Services Division "address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities (including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders)." [SEC. 2693. ø300ff–121)]

BPHC seeks proposals that are directed toward communities within the Boston EMA most disproportionately impacted by HIV/AIDS, including but not limited to communities of color; youth; persons formerly incarcerated; the gay, lesbian, bisexual, and transgender communities; immigrant population; and individuals with opioid-related comorbidities.

While all PLWHA from communities of color are eligible to receive services funded through the MAI program, the Boston EMA has prioritized programs that intend to reach the following populations:

- Black/African American
- Hispanics/Latinx
- American Indian
- Alaska Native
- Native Hawaiian
- Asian and Pacific Islander

Additional consideration for MAI funding will be given to proposals that demonstrate strong cultural awareness, linguistic capacity, and successful engagement strategies for hard-to-reach populations such as persons experiencing homelessness and persons who inject drugs.

AVAILABILITY OF FUNDING

The federal award for the Ryan White Services Program is expected to be announced by March 1, 2025, subject to Congressional appropriation and presidential signature. For planning purposes, the Boston EMA Ryan White Part A Planning Council projects a range of possible funding scenarios (level funding +/- $500,000), with individual service category allocations determined by the Planning Council's funding priorities.

Based on the new funding cycle Notice of Funding Opportunity ceiling amount, we do not anticipate the FY 2025 award to exceed **$15,808,987**, and the service award would not exceed **$13, 347, 640**.

FY 2025 Ryan White Part A Funding Projections		
Funding Type	**HRSA Service Category**	**FY 2025 Planning Council Allocation**
Core	AIDS Drug Assistance Program Treatments	$160,524
Core	Medical Case Management	$4,724,777
Core	Medical Nutrition Therapy	$1,164,935
Core	Oral Health Care	$1,505,958
Support	Emergency Financial Assistance	$221,372
Support	Food Bank/ Home Delivered Meals	$817,664
Support	Housing	$1,450,805
Support	Linguistics	$23,184
Support	Medical Transportation	$215,997
Support	Non-Medical Case Management	$977,372
Support	Other Professional Services	$52,921
Support	Psychosocial Support	$986,795
Total		**$12,541,401**

Minority AIDS Initiative (MAI) Services		
Core (MAI)	Medical Case Management (MAI)	$472,807
Support (MAI)	Emergency Financial Assistance (MAI)	$46,504
Support (MAI)	Non-Medical Cade Management (MAI)	$183,460
Support (MAI)	Psychosocial Support (MAI)	$108,638
Support (MAI)	Other Professional Services Legal (MAI)	$84,831
MAI Total		**$896,239**

Award Total	**$13,347,640**

APPLICANT ELIGIBILITY REQUIREMENTS

To be eligible for a Part A award, applicants **must** meet all the following requirements:

- Be a certified Non-profit 501(c)(3).
- Be located within the ten counties of the Boston EMA.
- Be Medicaid-certified if providing a Medicaid-covered service.
- Demonstrate fiscal viability. All applicants must have an operating reserve of at least

$500,000 for eligibility to directly apply for Part A funding. Subrecipients with an annual operating budget of less than $500,000 may apply only through a sponsoring agency that meets the requirement. The sponsoring agency will apply as the lead agency with a clearly defined relationship as the fiscal agent.

- Submit a copy of the agency's most recent Single Audit (for subrecipients that expend $1,000,000 or more in Federal funds) or internal audit (for those that expend less than $1,00,000 in Federal funds).
- Be providing services to PLWHA in the EMA.
- Be in full program/fiscal reporting compliance (currently funded subrecipients only).

Agencies will need to demonstrate they meet these additional requirements:

- Are located in/near the targeted community.
- Have a documented history of providing service to the targeted communities.
- Have documented linkages to the targeted populations.
- Provide services in a manner that is culturally competent and linguistically appropriate.
- Can demonstrate capacity to electronically document and report service delivery of the client to BPHC and HRSA in accordance with applicable guidelines.
- Can demonstrate data entry capacity to meet requirements of BPHC and HRSA.

BPHC may negotiate the funding of select segments of a proposal if other aspects can be funded more efficiently through different subrecipients. BPHC may also require an applicant to make appropriate linkages with other subrecipients and programs in order to receive funding.

FUNDING RESTRICTIONS

The following restrictions have been mandated by HRSA:

Payer of Last Resort

Grant funds may not be used to supplant or replace current State or local HIV-related funding.
Funds may not be used to purchase or improve land, or to purchase, construct, or make permanent improvements to any building except for minor remodeling.
Funds may not be used to make payments to recipients of services.
Recipients of grant funds must participate in a community-based continuum of care. A continuum of care is defined as:

10% Administration

Of the total amount of funds awarded to a service provider through Part A, the total expenditures for administrative expenses shall not exceed 10 percent. For the purposes of the 10% aggregate cost cap, administrative activities include:

- Usual and recognized overhead activities, including rent, utilities, and facility costs.
- Costs of management oversight of specific programs funded under this title, including program coordination; clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; and computer hardware/software not directly related to patient care.

Medicaid

If a particular service is available under the State Medicaid Plan, the political subdivision involved either must provide the service directly or must enter into an agreement with a public or private entity to provide the service. The subrecipient providing the service must enter into a participation agreement under the State Medicaid Plan and must be qualified to receive payment under the State Medicaid Plan.

Funds may not be used to provide items or services for which payment already has been made, or reasonably can be expected to be made, by third-party payers, including Medicaid, Medicare, and/or other State or local entitlement programs, prepaid health plans, or private insurance. It is therefore incumbent upon recipients of Part A funds to assure that eligible individuals are expeditiously enrolled in Medicaid and that Part A funds are not used to pay for any Medicaid-covered services for Medicaid-

eligible PLWHA. Applicants are reminded that Part A Recipients/Subrecipients are subject to audit on this and other restrictions on use of funds.

Sliding Fee-Scale

If a Part A service provider charges for services, it must do so on a sliding fee schedule that is made available to the public. Individual, annual aggregate charges to clients receiving Part A services must conform to statutory limitations (see chart). The intent is to establish a ceiling on the amount of charges to recipients of services funded under Part A. Please refer to the following chart for allowable charges.

Individual/Family Annual Gross Income and Total Allowable Annual Charges

Individual/Family Annual Gross Income	**Total Allowable Annual Charges**
Equal to or below the official poverty line	No charges permitted
101 to 200 percent above the official poverty line	5% or less of gross income
201 to 300 percent above the official poverty line	7% or less of gross income
More than 300 percent above the official poverty line	10% or less of gross income

Establishing a fee schedule should not result in a bureaucratic system to means-test individuals or families before Part A supported services are provided. A simple application that requests information on the annual gross salary of the individual/family should provide the baseline by which the caps on fees will be established. The client should ensure that the information is accurate.

Funds are to be used in a manner consistent with current and future program policies developed for Part A regarding allowable categories of services and eligibility for services. Please review all current HRSA, HIV/AIDS Bureau (HAB), and BPHC program policies, which can be found on the BPHC and HRSA websites, as well as the BPHC Providers' Manual. All travel must be local (within the EMA) and directly related to the services provided under the specific contract.

AGENCY MONITORING AND CLINICAL QUALITY MANAGEMENT

AGENCY MONITORING

Every subrecipient of Ryan White Part A funding will receive an annual monitoring visit from BPHC. The City of Boston is a Recipient. Funded Subrecipients will not have contact directly with HRSA. BPHC is required to work on HRSAs behalf to monitor and evaluate all Part A-funded Subrecipients and ensure each Subrecipient meets minimum standards for executing the award. The visit includes various quality assurance activities, including a review of a random sample of records for clients who receive services at the program. BPHC will spend time at each monitoring visit collecting information from the program and service delivery portion as well as the fiscal controls of each subrecipient.

The primary focus of the monitoring activities is the following:

1. ***Verify eligibility for Part A services***. All clients who receive Part A services are required to document proof of HIV status, proof of financial eligibility (earning < 500% FPL), proof of residency in the Boston EMA, and proof of health insurance status. These eligibility criteria are defined by HRSA and apply to all Part A-funded programs.
2. ***Verify that activities are allowable***. Subrecipients funded for Part A must propose a program model that meets the HRSA definition of the service category. The program must also adhere to the Service Standards for HIV Services. At the time of a monitoring visit, the recipient must verify that the activities delivered on-site are allowable, relate directly to the definition of the service category, and meet all universal and service-specific standards for HIV services. All programs funded under Part A will have access to comprehensive Service Standards documents, as well as a Provider Manual and other guidance.
3. ***Review and test policies related to grant administration and service delivery***. In the weeks leading up to a monitoring visit, BPHC will provide a comprehensive list of policies that are required to be presented at the visit and adhered to throughout the grant cycle. As mentioned above, BPHC reviews and tests these policies to ensure that each subrecipient meets the standards outlined by HRSA and other federal entities about grants administration. Many of the policies are related directly to the daily activities of the funded program. Other policies are related to the daily fiscal and accounting practices of the subrecipient. Each of the items plays in part in demonstrating that the subrecipient understands the scope of the award and contract and has the resources and foundation within the subrecipient to effectively execute the contract.
4. ***Verify the subrecipient meets all federal and state requirements for grant administration***. The fiscal compliance activities that occur during a monitoring visit test the overall fiscal health of a subrecipient. This includes testing a subrecipient's accounting practices and procedures, policy implementation, hiring practices, and spending patterns, among others. In addition to, the guidance outlined by HRSA, all recipients of federal grants and awards must be knowledgeable in and follow Uniform Guidance as outlined by the Office of Business and Management.
5. ***Measure service delivery and data quality***. The CQM team, contract managers, and Data Manager will periodically review the agency's client eligibility, utilization, outcome measure distribution, and demographic reports on E2Boston to analyze agency performance. Utilization review will occur monthly with contract managers, coupled with discussions on service delivery. Review of other named reports will occur quarterly and will be discussed with the agency if deemed necessary.

BPHC will need to interface with staff in different roles at the subrecipient agency, including but not limited to, program managers, direct line staff members, accountants, controllers, grants management staff, and procurement specialists. The monitoring visit will assess a subrecipient's overall ability to effectively execute a federal award and meet the standards outlined by federal guidelines. Outcomes of the visit will be providing in writing via the programmatic and fiscal reports. If deemed necessary, BPHC has the right to assign the subrecipient on a corrective action plan (CAP), to ensure that the program staff work on addressing the outcomes within the timeline agreed upon.

CLINICAL QUALITY MANAGEMENT

HRSA Policy Clarification Notice (PCN)15-02 requires all Ryan White recipients (Parts A-D) to have established Clinical Quality Management (CQM) programs. CQM-specific aims must be based on health outcomes, dedicated infrastructure, and the use of data and measurable outcomes to assess the success of current interventions and activities, identify gaps in these services, and help determine the next steps.

BPHC is committed to providing all subrecipients with the tools and resources necessary in the form of TA, webinars, etc., to assist subrecipients in implementing quality improvement projects.

PCN 15-02 also requires the recipient (BPHC) to provide clear expectations and sufficient resources, including quality improvement training and technical assistance, to subrecipients to participate in CQM initiatives. All Ryan White subrecipients will be required to build quality improvement infrastructure, submit and analyze performance level data, and complete at least one yearly quality improvement project using a defined QI methodology (Lean, Six Sigma, Model for Improvement, etc.).

Infrastructure

Ryan White Quality of Care Committee: An advisory committee representative of the demography of the EMA that guides, advises, and provides feedback on all aspects of the Ryan White Clinical Quality Management Program.

Clinical Quality Management (CQM) Plan: The BPHC CQM Plan details a three-year strategy to improve the quality of Ryan White services. This plan highlights the quality improvement goals of the Boston EMA and includes a plan to measure program performance. The CQM Program will continue to support the overall EMA goals to build a quality improvement culture among subrecipients and to increase viral suppression among PLWHA. You can find an up-to-date version of the CQM Plan in the e2Boston Resource Center, or on our website.

IHI Open School: The CQM Program maintains an IHI Open School group subscription with licenses for Ryan White Part A stakeholders who are looking to enhance their skill set in conducting improvement work. This subscription is free of cost to Ryan White Part A stakeholders and lasts for up to one year, with the option to renew. Please contact the CQM Team at cqm@bphc.org if you would like to discuss your QI learning goals and coursework in Open School that can help you achieve them.

e2Boston: e2Boston is a cloud-based database that houses client-level information for Part A and the Ending the HIV Epidemic grant. Every funded provider under these two grants is required to enter clients' eligibility, demographic, medical, services, and health outcome information into e2Boston. The CQM Program relies heavily on the aggregate reports that are generated in e2Boston to understand program performance in the Boston EMA. This helps the CQM Team and Quality of Care Committee to identify areas of improvement, quality gaps, and improvement success.

Performance Measurement

Quarterly Data Displays: A data display is a visual tool that displays each subrecipient's performance

measure data based on e2Boston data. Examples of performance measures include gaps in medical visits and viral suppression rates for clients. Each quarter, CQM staff will create and share data displays for a subset of services across the EMA, currently including Medical Case Management, Non-Medical Case Management, Oral Health, Housing, and Food Bank/Home Delivered Meals. This visual tool displays aggregate client outcomes over time and can be used as a basis for developing data-driven quality improvement initiatives to improve client outcomes.

e2Boston Reports: The CQM Team uses the HRSA HIV/AIDS Bureau (HAB) Measures, Outcomes Measure Distribution, and Demographics reports to evaluate program quality and identify improvement needs. CQM staff also use the Performance Summary report, Outcomes Submission Status report, and System Alerts to help monitor data quality. Subrecipients are encouraged to run the Outcomes Submission Status report and/or check System Alerts at least once per month to help ensure timely and accurate entry of Outcomes data. Please note that e2Boston users can opt to subscribe to weekly email summaries of system alerts.

Quality Improvement (QI) Culture Assessment: The purpose of this assessment is to evaluate the current quality improvement activities and capacity of subrecipients and to identify strengths as well as opportunities to improve. The assessment informs the CQM Team of subrecipients' QI goals and projects and serves as a benchmark for improvement projects. The CQM Program administers this assessment annually, at the start of each calendar year.

Technical Assistance

Monthly Monitoring Calls: CQM-specific questions are incorporated into the monthly call agenda that is facilitated by each subrecipient's Contract Manager. These questions serve as a check-in on the quality improvement work and opportunities in each Part A program and create a space for open discussion about performance measures. This component of the monthly monitoring calls is meant to promote a culture of continuous Quality Improvement and ensure that Subrecipients are efficiently connected with CQM staff for any needed TA.

Performance Measure Guides: Every other month, one Performance Measure (i.e. Housing Status, Viral Suppression, etc.) will be discussed during the monthly calls described above. At the conclusion of the month, subrecipients will receive a guide that provides an overview of that measure: the definition, how it's entered in e2Boston, and how it is reported. These guides will be sent out via the RWS newsletter and accessible from the e2Boston Resource Center.

CQM Office Hours: CQM staff now offer office hours to all Part A subrecipients for technical assistance and other CQM-related questions!

e2Boston Training: Please refer to the e2Boston Resource Center for training content pertaining to data entry and reports, including entry of Outcomes data and utilization of CQM reports.

Supplementary CQM resources: In the e2Boston Resource Center under the section labeled "CQM

Information." These additional resources provide subrecipients with up-to-date Ryan White CQM initiatives and relevant explanatory material. Subrecipients are encouraged to utilize these materials and the CQM Office Hours to ensure their QI initiatives are implemented with evidence-based practices and methodology.

CQM Expectations of Subrecipients

1. Participate in monthly call discussions about CQM. We encourage subrecipients to consider which funded staff should be part of quality work and conversations.
2. Complete the annual QI Culture Assessment.
3. Enter clients' health outcomes data into e2Boston once every six months.
4. All e2Boston users should complete e2Boston training videos/slides, which can be found in the e2Boston Resource Center.
5. Use e2Boston reports to better understand the quality and performance of your Ryan White service(s).

Quality Improvement

Quality Improvement (QI) Projects and Initiatives: Part A subrecipients are encouraged to engage in QI projects and/or initiatives each fiscal year. The CQM Program can support these projects that aim to improve client care, health outcomes, and client satisfaction among Part A clients within the Boston EMA. CQM staff can provide technical assistance, QI training, tools, other resources, and financial assistance through mini-grant funding for projects that align with system-wide priorities.

Quality Improvement (QI) Learning: The CQM Program aims to support learning opportunities related to high-priority improvement areas (as determined by the CQM Committee) and provide a library of QI resources and training modules for Ryan White stakeholders within the Boston EMA.

Consumer Capacity: The CQM Program is committed to training consumers to build their capacity in Quality Improvement methodology.

FUNDING PRINCIPLES AND SERVICE STANDARDS

PLANNING COUNCIL FUNDING PRINCIPLES

Every year the Planning Council votes on a set of funding principles that guide the work of the Council, the Recipient (BPHC), and the funded network of service category(s). The funding principles have evolved over the years to better respond to the needs of PLWHA and provide an accurate guide to the recipients and service providers.

The current FY 25 funding principles, as approved by the Planning Council are available for viewing and can be downloaded or printed from the Boston Planning Council website: http://www.bphc.org/whatwedo/infectious-diseases/Ryan-White-Services-Division/boston-planning-council/publicatons/Pages/Publications.aspx

SERVICE STANDARDS

The primary goal of the Boston EMA Service Standards is to maintain the integrity and quality of all Part A services offered in the Boston EMA while clearly following the guidance of HRSA Policy Clarification Notices (PCN), the National Monitoring Standards, and the Ryan White Legislation. The expectation is that programs in the Boston EMA will adapt to meet HRSA's policy changes and updates to the National Monitoring Standards.

The Universal and Service Specific Service Standards are aligned with HRSA Monitoring Standards and HRSA Policy Clarification Notice 16-02 to meet the most current definition of service categories under Ryan White Part A. All allowable activities are to be categorized under the appropriate service category and monitored by the guidance of the Service Standards.

Collaboration on the Service Standards includes subrecipients of Part A funding, consumers of HIV services, stakeholders, and members of the community at large. The document was completed with feedback and approval from the Boston EMA Ryan White Planning Council.

All applicants and contracted subrecipients are expected to meet these Standards. Subrecipients not meeting these Standards will be required to implement a corrective action plan. The Service Standards

are used to ensure uniform quality of all Part A services in the Boston EMA, regardless of location.

The Planning Council has established Service Standards for all service categories. Descriptions of service-specific Service Standards for each category are provided in the Service Description Section of this document. The following are the current Universal Service Standards:

Universal Service Standards

- Policies and procedures are in place that protect clients' rights and ensure quality of care.
- Clients access the highest quality of services through experienced, trained, and when appropriate, licensed staff.
- Program meets federal and state requirements for safety, sanitation, access, public health, and infection control.
- Client confidentiality is guaranteed, client autonomy is protected, and a fair process of grievance review and advocacy is implemented.
- Client eligibility is established, client information is collected through an intake process, and clients receive comprehensive information about services.

- Client needs are assessed, and informed, active client participation is encouraged.
- Client needs are effectively addressed through coordination of care with appropriate collateral providers and referrals to needed services.
- Access is facilitated for all PLWHA in need of and eligible for services.
- The program is physically accessible to all PLWHA.
- Staff are trained and capable of delivering services in a culturally and linguistically competent manner.

Service Specific Service Standards

Service Standards for all Core Medical and Support Part A Services have been revised in accordance with updated HRSA requirements *(Appendix D)*. **Applicants are strongly encouraged to thoroughly review the service-specific Service Standards appropriate to your programming to confirm that these services align with HRSA's updated regulations.**

Full versions of both the Universal and Service Specific Service Standards are available for viewing and can be downloaded or printed from the Ryan White Services Division website https://www.boston.gov/government/cabinets/boston-public-health-commission/infectious-diseases/ryan-white-services-division.

DEFINITION OF SERVICES

Services are defined by the Ryan White HIV/AIDS Program Legislation and current policy clarifications set forth by the Health Services and Resources Administration (HRSA). Services are further defined by the service region's established Service Standards. Funded services must be delivered in compliance with Ryan White's legislative requirements.

The previous service category portfolio in the Boston EMA funded twelve (12) service categories. In response to the changing needs of the HV community, as identified through Community Listening Circles and provider surveys, BPHC seeks to fund four Core Medical (1-4) and eight (5-12) Support Part A Services through this RFP.

Core Medical Services include AIDS Drug Assistance, Medical Case Management, Medical Nutrition Therapy, and Oral Health Care.

Support Services include Housing, Psychosocial Support, Food Bank Home Delivered Meals, Medical Transportation, Non-Medical Case Management, Other Professional Services Legal, Emergency Financial Assistance, and Linguistics Services.

Each service is reviewed separately with a detailed description organized into the following sections:

FY 2025 Planning Council Allocation: The FY 2025 Planning Council Allocation reflects the funding amount that the Boston EMA's Planning Council has determined for the respective service category for the fiscal year.

HRSA Definition and Description and HRSA Program Guidance: The HRSA Definition and Description and HRSA Program Guidance is a description of the respective service category as it is defined by HRSA.

Eligibility: The Eligibility section informs subrecipients of the minimum eligibility requirements for each respective service category, including the Universal Service Standards.

Description of Service: The Description of Service section identifies the specific service activities that construct the respective service category.

DEFINITION OF CORE MEDICAL SERVICES

1. AIDS DRUG ASSISTANCE PROGRAM TREATMENT (ADAP)

FY 2025 Planning Council Allocation: $160,524

HRSA DEFINITION AND DESCRIPTION

The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the Ryan White HIV/AIDS Program (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 assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services to ensure that purchasing health insurance is cost effective in the aggregate.

HRSA PROGRAM GUIDANCE

RWHAP Parts A, C and D recipients may contribute RWHAP funds to the Part B ADAP for the purchase of medication and/or health insurance for ADAP-eligible clients.

ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide AIDS Drug Assistance (ADAP) services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

All applicants must demonstrate their capacity to provide the following service elements:

Prescription

FDA-approved medications to income-eligible individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

2. MEDICAL CASE MANAGEMENT (MCM)

FY 2025 Planning Council Allocation: $4,724,777
FY 2025 Planning Council Allocation (MAI): $472,807

HRSA DEFINITION AND DESCRIPTION

Medical Case Management (MCM) 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. MCM 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, and
- Client-specific advocacy and/or review of utilization of services.

In addition to providing the medically oriented services above, MCM 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).

HRSA PROGRAM GUIDANCE

MCM 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.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a MCM visit should be reported in the MCM service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide MCM services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

MAI ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide MCM services for PLWHA within the Boston EMA that "address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities (including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders)." [SEC. 2693. ø300ff–121)] Additional consideration for MAI funding will be given to proposals that demonstrate strong cultural awareness, linguistic capacity, and successful engagement strategies for hard-to-reach individuals.

Proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

Medical Coordination

MCM services should focus on improving health outcomes by reducing HIV-related health disparities and health inequities as well as conducting referrals to internal or partnering service providers. The goals of medical care coordination are to ensure clients are linked to care, engaged in care, achieve viral suppression, and maintain viral suppression. Medical care coordination includes, but is not limited to, the following: tracking medical appointments, facilitating communication with medical providers (including HIV, primary care, viral hepatitis and other specialty care providers), facilitating communication with pharmacists, helping clients prepare for and make medical appointments, ensuring that clients have transportation and child care in order to attend medical appointments, accompanying clients to medical appointments, developing and/or implementing appointment reminder strategies, supporting access to and coordination with mental health and/or substance abuse services, pain management services and other activities related to health systems navigation. All efforts should contribute to the goal of viral suppression.

Treatment Adherence

Adherence Support is the provision of services that ensure readiness for, and adherence to HIV treatments. MCM programs providing Adherence Support must be up-to-date on the latest HIV medical advances and treatment approaches and must coordinate these services with the client's HIV medical care provider and pharmacist. Adherence Support may include, but is not limited to, the implementation of adherence assessments, providing information related to the importance of adherence relative to disease transmission and viral load, engagement in discussions about potential or actual adherence challenges, and the development of practical action plans to address these concerns. MCM providers will be expected to maintain updated information on adherence strategies, which may include various types of medication reminders; scheduling strategies around sleep, work, travel, or other activities; coordination of adherence support with pharmacists; and methods of maintaining privacy and confidentiality.

Behavioral Health and Substance Use
Comprehensive services for PLWHA must include guidance and practical support related to behavioral health, transmission prevention, and risk reduction. This level of service requires MCM providers to counsel clients during visits to review accurate information related to behavioral health, sexual health and substance use risk and to identify and work to remove barriers to HIV treatment adherence. Discussions should be client-centered, rooted in a harm reduction framework, and considered part of the continuum of services that are offered to clients to promote health and quality of life. They should also focus on identifying and addressing barriers to clients achieving and maintaining viral suppression.

As part of this process, MCM providers are expected to engage clients in discussions regarding their behavioral health status. Providers should inquire about a client's well-being and their ability to function in everyday life as well as address any concerns regarding stress, depression, anxiety, relationship problems, grief, addiction, mood disorders, and other psychological issues. Providers are expected to link clients to timely behavioral health services along with providing them with information about healthy decision making and healthy behaviors.

MCM staff must be able to talk explicitly about substance use and abuse, and drug injection behaviors; sterile injection equipment, and bleach kits; and can demonstrate/teach proper use of these products. Staff must be able to support client access to sterile injection equipment, syringe exchange, and/or syringe disposal services in addition to overdose prevention services and must have internal or external referral mechanisms with providers that offer viral hepatitis and STI screening, STD treatment, and hepatitis A and B vaccination (as appropriate).

Benefits Counseling
MCM providers are expected to help clients access financial benefits, health insurance coverage, and, state and federal entitlements that will support their economic, residential, medical, and social stability. Providers must, during the assessment process, determine existing access to and need for benefits and entitlements. Based on this information, providers must either provide the client with the Benefit Counseling service directly or via an established partnership with a Benefits Counseling provider.

Providers must have detailed knowledge of resources available through the U.S. Social Security Administration (SSI/SSDI), Massachusetts Department of Transitional Assistance (EAEDC, TAFDC), Medicaid, Medicare, HIV Drug Assistance Program (HDAP), and private health insurance options, including those offered through the MA Health Connector and Comprehensive Health Insurance Initiative (CHII). Providers in New Hampshire are similarly expected to be knowledgeable about resources available through NH state Subrecipients and programs, such as the NH DHHS, including NH CARE, New Hampshire Health Protection Program, and Division of Family Assistance. Applicants for this service area must describe how staff will remain informed and up-to-date about policy and programmatic changes and how services will be made accessible to clients. Applicants may describe models that provide the Benefits Counseling service component to MCM teams, including throughout posting, by means of Memoranda of Agreement.

Acuity Assessment
MCM services are primarily intended to serve high-acuity clients, whereas the NMCM service category is intended to provide case management to low-acuity patients. BPHC requires that both MCM and NMCM programs develop an acuity assessment to be conducted at intake to determine the level of care needed by the client. If a client is identified as a high-acuity client, then client may continue to receive

services at the program. A high-acuity client may include a client that is not virally suppressed, experiencing challenges with medication adherence, behavioral health and substance abuse, and homelessness. If a client is identified as a low-acuity client, then the MCM program must refer client to an internal or partnering NMCM service provider. Assessments should be conducted every six months to determine client's acuity.

STAFFING

Multidisciplinary Teams

Funding is prioritized for MCM services that integrate a multidisciplinary team approach. A central objective of this approach is to maximize service access and coordination by offering a comprehensive MCM service that is provided by individuals with complementary expertise and skills. It is expected that these teams will look different across programs and will incorporate a range of provider expertise. Applicants must submit job descriptions for the roles that will comprise their MCM teams.

Medical Case Managers and Medical Case Manager Supervisors

It is expected that MCM providers have the credentials, skills, and experience to offer high quality services. Each MCM service component requires a significant knowledge base and skill set. Applicants are strongly encouraged to determine appropriate qualifications for each position within the MCM team, and to propose salaries that are commensurate with these qualifications.

MCM service providers must ensure that staff members have an advanced understanding of issues that will enable them to effectively support clients in coordination with the HIV medical care provider. These issues include, but are not limited to interpretation of laboratory tests, medication adherence strategies, HIV disease processes and treatment, side effect management options, quality standards of appointment frequency, and insurance coverage rules.

Subrecipients directly providing benefits counseling must have strong familiarity with state and federal benefits programs including Medicaid, Medicare, Social Security, and Department of Transitional Assistance programs and the associated eligibility criteria and application procedures.

MCM administrative and clinical supervisors must actively maintain an understanding of BPHC requirements to fully support staff members who are providing direct services to clients. Administrative supervisors must ensure that the staff they oversee are accessing education, training, mentoring, and technical assistance that help them develop professional knowledge and skills. Proposals with staffing models that include administrative supervisors who have advanced degrees in related fields (i.e., social work, nursing, counseling, etc.) will be favorably considered. All funded MCM providers will be required to attend BPHC's MCM Training and Capacity Building program's training.

3. MEDICAL NUTRITION THERAPY

FY 2025 Planning Council Allocation: $1,164,935

HRSA DEFINITION AND DESCRIPTION

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.

HRSA 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.

ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide Medical Nutrition Therapy services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

All applicants must demonstrate their capacity to provide the following service elements of Medical Nutrition Therapy.

Nutrition Assessment/Screening

Medical Nutrition Therapy services should focus on improving health outcomes by assisting people living with HIV/AIDS to achieve optimal nutrition by creating a dietary plan that compliments the individual's medication adherence. Each client should receive a comprehensive assessment based on a referral from a medical provider, which includes indicating any barriers that prevent the client from accessing appropriate dietary options. Based on this assessment, providers can develop a unique dietary evaluation and subsequent nutritional plan.

Dietary / Nutritional Evaluation

This service component aims to determine the specific dietary needs of clients accessing Medical Nutrition Therapy. The Dietary/Nutritional Evaluation should be based on the Nutritional Assessment/Screening conducted per a medical provider's referral. The evaluation should highlight specific changes and/or additions to the client's diet, including the following:

- Recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food;
- The signature of the referring medical provider and each registered dietician who rendered service, the date of service;

- Date of reassessment;
- Date of initiation and termination of medical nutrition therapy;
- Any recommendations for follow up;
- Planned number and frequency of sessions;

Food and Nutritional Supplements
Food items and supplements may be directly provided to the client if the provider has access to them. These items must align with the action items described in the Dietary/Nutritional Evaluation.

Nutrition Education & Counseling
The aim of this service component is to dissolve barriers to care that involve the client's own knowledge of their dietary needs. Nutrition Education & Counseling should be administered in a culturally competent manner and companion materials should be administered in the language most comfortable for the client.

STAFFING
All activities under Medical Nutrition Therapy need to be administered by a licensed dietician or nutritionist.

4. ORAL HEALTH CARE

FY 2025 Planning Council Allocation: $1,505,958

HRSA DEFINITION AND DESCRIPTION

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.

ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide Oral Health Care services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

All applicants must demonstrate their capacity to provide the following service elements.

Intake

The intake is usually the first encounter between the program and the client. The purpose of intake is to inform the client of dental services available and what the client can expect if s/he enrolls in services; to establish client eligibility for dental services; to provide client with referral information to other services, as appropriate; to collect required city/state/federal client data for reporting purposes; and to collect basic client information to facilitate client identification and client follow-up.

Treatment Plan

The purpose of the treatment plan is to guide the dental provider in delivering high quality care corresponding to the client's level of need including determination of emergency versus non-emergency care, triage care and referral as needed. The treatment plan should include: description of documented client need, including relevant dental, medical, and prescription information; level of service need, time frames within which services are to be provided; who will be the provider of the service; and notes on required monitoring, assessment or coordination of care with collateral providers.

Treatment Committed

Treatment committed refers to prior approval granted by the Dental Program to a participating dental provider for services which exceed routine care. A treatment plan must be submitted to obtain such approval.

Treatment Claim

A dental claim form submitted for reimbursement of services rendered.

Additionally, applicants must demonstrate their ability to recruit, train, and maintain a network of dentists throughout the EMA. Applicants must also demonstrate how they would administer a single dental fund and provide timely and appropriate reimbursements to enrolled dentists.

DEFINITION OF SUPPORT SERVICES

5. EMERGENCY FINANCIAL ASSISTANCE (EFA)

FY 2025 Planning Council Allocation: $221,372
FY 2025 Planning Council Allocation (MAI): $46,504

HRSA DEFINITION AND DESCRIPTION

Emergency Financial Assistance (EFA) 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 subrecipient or through a voucher program

HRSA 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.

ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide EFA services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

MAI ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide EFA services for PLWHA within the Boston EMA that "address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities (including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders)." [SEC. 2693. ø300ff–121)] Additional consideration for MAI funding will be given to proposals that demonstrate strong cultural awareness, linguistic capacity, and successful engagement strategies for hard-to-reach individuals.

Proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

EFA Voucher

Limited one-time or short-term payment(s) to assist with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication.

6. FOOD BANK/HOME DELIVERED MEALS

FY 2025 Planning Council Allocation: $817,664

HRSA DEFINITION AND DESCRIPTION

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.

HRSA PROGRAM GUIDANCE

Unallowable costs include household appliances, pet foods, and other non-essential products.

ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide Food Bank/Home-Delivered Meals services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

Home Delivered Meals

All agencies applying for home-delivered meal funding must utilize medical eligibility criteria to determine client eligibility. The subrecipient must describe the program's screening procedures and must specify eligibility criteria used, the person responsible for eligibility screening, how determination is made, and process for recertification. (*See Medical Nutrition Therapy.)*

Note: Subrecipients providing hot meals on site must fully assess a client's need for a hot meal including client's access to food and nutritional needs, ability to prepare hot meals, and frequency of need on a weekly basis. Programs must provide an option for clients to pick up meals the client can take home.

Food Bank Packages

All agencies applying to distribute food bank packages must ensure that all packages contain nutritionally balanced food items that are appropriate for the dietary needs of individuals living with HIV/AIDS. Packages may be made available at community-based organizations or clinical sites. An internal case management program will identify client need for this service. All food purchases should be reviewed by a licensed dietician or nutritionist prior to distribution.

Food Voucher Programs

All agencies applying for food voucher funding must demonstrate that an internal case management program will determine eligibility for the food voucher program and will coordinate the food voucher service delivery. All Subrecipients providing food vouchers must have a monitoring process that ensures that food vouchers are only utilized to purchase food and personal hygiene products and that food vouchers may not be exchanged for cash or any other items

7. HOUSING SERVICES

FY 2025 Planning Council Allocation: $1,460,805

HRSA DEFINITION AND DESCRIPTION

Housing services provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services must include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing services can include housing referral services; assessment, search, placement, and advocacy services; as well as fees associated with these services.

Eligible housing can include either housing that:

- Provides some type of core medical or support services, e.g., residential substance use disorder services or mental health services, residential foster care; or assisted living residential services; or
- Does not provide direct core medical/support 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. The necessity of housing services for the purposes of medical care must be documented.

HRSA PROGRAM GUIDANCE

RWHAP recipients and subrecipients must have mechanisms in place to allow newly identified clients access to housing services. RWHAP recipients and subrecipients must assess every client's housing needs at least annually to determine the need for new or additional services. RWHAP recipients and subrecipients must develop an individualized housing plan for each client receiving housing services and update it annually. RWHAP recipients and subrecipients must provide HAB with a copy of the individualized written housing plan upon request.

RWHAP Part A recipients, subrecipients, and local decision-making planning bodies are strongly encouraged to institute duration limits to housing services. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients and subrecipients consider using HUD's definition as their standard.

Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide the Housing services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

Housing stability is critical to maintaining engagement in medical care and health-related support services. Housing referral services focus on temporary and permanent housing placements that assesses

and provides search, placement, and advocacy services, as well as fees associated with these services. All applicants must demonstrate capacity to provide the following when administering housing services.

Assessments

Providers must develop or implement comprehensive initial assessment tools that reveal a client's barriers to housing, and subsequently target those barriers in a treatment plan. The Assessment tool is expected to be completed within 30 days of a client's intake into Housing services. The goal of the assessment at initial intake is to determine a client's immediate housing needs and eligible services, and to identify barriers that are contributing to housing instability, ultimately moving a client to a stable housing status. At a minimum, the assessment tool must collect the following client information regarding its impact on housing stability:

- Safety and security status,
- Interest and/or need to relocate,
- Current living arrangements,
- Client housing history,
- Degree of rent burden,
- Outstanding legal issues,
- Substance Abuse history,
- Support networks, and
- Medical needs.

The assessment must also determine if a client has a Medical Case Manager or other social support services; and ensure that the housing service is not duplicating services provided by another provider. Housing programs may work in tandem with a Medical Case Manager or other social support service to meet the client's needs, but each provider must have a specific role in the client's service plan.

Reassessments

A reassessment must be conducted every 6 months for clients enrolled in housing services. The goal of the reassessments is to capture any changes to the above-mentioned categories that have occurred since the previous reassessment or assessment, and that may affect the client's housing goals or the approach of the housing advocate. Client progress notes should be used as a reference point to complete elements of the reassessment.

Individual Service Plans

Providers should use various client-centered methods, such as motivational interviewing and harm reduction, to engage PLWHA in need of safe, affordable, long-term housing. Together advocates and clients will develop a strategy to address clients' barriers to housing stability and viral suppression by creating an Individual Service Plan (ISP).

ISPs are goal-oriented and must include action steps that follow the SMART model (Specific, Measurable, Achievable, Relevant, and Time-bound). Housing providers must provide services that will assist clients who have difficulty identifying goals by making connections between clients' needs and available housing-related resources. Acceptable ISPs will:

- Address barriers identified in the client's assessment;

- Include activities and resources that support housing stability;
- Clearly outline the role of the Housing Advocate;
- Ensure services do not duplicate Medical Case Management and/or Non-Medical Case Management activities or treatment plans; and
- Describe how stable housing will be maintained if the client receives short-term financial assistance or is discharged from services.

Housing Search
Providers will assist clients with assessing service eligibility, submitting complete applications, and educating clients about available resources, including other housing and/or utilities subsidies. Providers are expected to maintain current information on relevant state, local, public and private housing options for clients seeking assistance. Housing search must include submitting applications for clients for all possible subsidies for which they qualify. Providers are expected to support clients address barriers to successful applications, such as an unresolved CORI, a poor credit history, or low-literacy.

Housing Advocacy
Providers will assist clients with establishing relationships with landlords and property managers, remedying unresolved court cases that influence acceptance to housing programs, and providing appeal assistance. Referrals and phone calls will facilitate access to support services as needed, such as financial and/or legal assistance.

Housing Advocacy may be conducted one-on-one with client, or in group settings to increase program capacity and efficiency. Group activities may take the form of educational sessions that educate clients in how to address common barriers. The sessions must focus on preparing a client for success and sustainability in a housing placement. Sample topics may include budgeting strategies, resources to necessities such as food and utility services, resolving open court case, and maintaining relationships with landlord or property management entity

Housing Placement
Clients begin residency in permanent or transitional housing, which is culturally appropriate and facilitates access to a range of medical and support services including primary medical care, adequate housing, legal services, transportation, mental health care, and detox/substance abuse treatment, if required (see HRSA definition for eligible settings).

8. Linguistics

FY 2025 Planning Council Allocation: $23,184

HRSA DEFINITION AND DESCRIPTION

Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities 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 HRSA RWHAP-eligible services.

HRSA PROGRAM GUIDANCE

Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide Linguistics Services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

All applicants must demonstrate their capacity to provide the following service elements:

Translation/Interpretation Services

Providers must work with clients and either have certified multilingual staff who are able to provide in-person translation and/or contract a team to provide services both internally and externally. Providers must accept referrals from outside agencies to aid in translating documents to additional languages.

STAFFING

All staff must provide qualified services that are culturally and linguistically appropriate.

9. MEDICAL TRANSPORTATION

FY 2025 Planning Council Allocation: $215,997

HRSA DEFINITION AND DESCRIPTION

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

HRSA 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 a lease, loan payments, insurance, license, or registration fees

ELIGIBILITY

For FY 2025, BPHC seeks applications from agencies that demonstrate the ability to provide medical transportation services for PLWHA within the Boston EMA. Applicants must ensure that Medical Transportation service planning assess a client's transportation needs and attempt to secure free or low-cost transportation resources that are available in the community or through benefits or entitlement programs, such as the MassHealth Prescription for Transportation (PT-1) program or The Ride, the Massachusetts Bay Transit Authority's (MBTA) transit program for people with disabilities. When no other options are available, and/or in situations considered an emergency, Subrecipients may offer transportation services directly in the form of bus/subway/train/other fares or taxi fares (paid directly to the taxi company). In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

All applicants must demonstrate their capacity to provide at least one of the following service elements of a transportation program:

Public Transportation Ride

The purpose of a one-way ride by public transportation is to provide transportation for clients to access healthcare or support services.

Taxi Ride
The purpose of a one-way ride in a taxi is to provide transportation for clients to access healthcare or support services.

Van Ride
The purpose of a one-way ride in a company funded vehicle is to provide transportation for clients to access healthcare or support services.

Volunteer Ride
The purpose of a one-way ride by a volunteer is to provide transportation for clients to access healthcare or support services.

Rideshare Ride
The purpose of a one-way ride by a rideshare company is to provide transportation for clients to access healthcare or support services.

10. NON-MEDICAL CASE MANAGEMENT

FY 2025 Planning Council Allocation: $977,372
FY 2025 Planning Council Allocation (MAI): $183,460

HRSA DEFINITION AND DESCRIPTION

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

HRSA 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.

ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide Non-Medical Case Management services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

MAI ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide Non-Medical Case Management services for PLWHA within the Boston EMA that "address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities (including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders)." [SEC. 2693. ø300ff–121)] Additional consideration for MAI funding will be given to proposals that demonstrate strong cultural awareness, linguistic capacity, and successful engagement strategies for hard-to-reach individuals.

Proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service

DESCRIPTION OF SERVICES

Social Services Coordination

This service component focuses on improving access to health care, which includes assisting clients in identifying social service needs and accessing resources. Social Services Coordination may include but is not limited to: initiating referrals; scheduling appointments; securing transportation and/or distributing transportation vouchers; identifying food resources and/or distributing food vouchers; brokering access to benefits counseling; providing housing search and advocacy and districting housing vouchers; communicating with other Subrecipients regarding service delivery; making referrals to volunteer opportunities, job training, or employment programs; providing basic household budgeting assistance; or offering assistance with daily living skills.

Behavioral Health and Substance Use

Comprehensive services for PLWHA must include guidance and practical support related to behavioral health, transmission prevention, and risk reduction. This level of service requires MCM providers to counsel clients during visits to review accurate information related to behavioral health, sexual health and substance use risk and to identify and work to remove barriers to HIV treatment adherence. Discussions should be client-centered, rooted in a harm reduction framework, and considered part of the continuum of services that are offered to clients to promote health and quality of life. They should also focus on identifying and addressing barriers to clients achieving and maintaining viral suppression.

As part of this process, NMCM providers are expected to engage clients in discussions regarding their behavioral health status. Providers should inquire about a client's well-being and their ability to function in everyday life as well as addressing any concerns regarding stress, depression, anxiety, relationship problems, grief, addiction, mood disorders, and other psychological issues. Providers are expected to link clients to timely behavioral health services along with providing them with information about healthy decision making and healthy behaviors.

NMCM staff must be able to talk explicitly about substance use and abuse, and drug injection behaviors; sterile injection equipment, and bleach kits; and can demonstrate/teach proper use of these products. Staff must be able to support client access to sterile injection equipment, syringe exchange, and/or syringe disposal services in addition to overdose prevention services and must have internal or external referral mechanisms with providers that offer viral hepatitis and STI screening, STD treatment, and hepatitis A and B vaccination (as appropriate).

Housing Search and Advocacy

BPHC has a long history of funding services in supportive housing programs and recognize that residential stability is a critical part of maintaining engagement in medical care and health-related support services to achieve and maintain viral suppression. NMCM services described in this procurement are consistent with objectives articulated by the United States Interagency Council on Homelessness which include integrating health care services with homeless assistance programs and housing.

In recognition of the connection between housing stability and health outcomes, NMCM providers are expected to help clients access and maintain housing. Providers should, during the assessment process, determine current housing status and percent of income spent on rent, assess housing safety and security, and discuss client interest/need to relocate. NMCM programs may choose to bid for the Housing service category and perform housing search & advocacy and/or provide housing assistance through their

NMCM program. If NMCM programs choose to not provide housing services internally, then they must have partnerships other RWPA service providers offering housing services as part of their Integrated Care Model.

Benefits Counseling

NMCM providers are expected to help clients to access financial benefits, health insurance coverage, and state and federal entitlements that will support their economic, residential, medical, and social stability. Providers must, during the assessment process, determine existing access to and need for benefits and entitlements. Based on this information, providers must either provide the client with the Benefit Counseling service directly or via an established partnership with a Benefits Counseling provider.

Providers must have detailed knowledge of resources available through the U.S. Social Security Administration (SSI/SSDI), Massachusetts Department of Transitional Assistance (EAEDC, TAFDC), Medicaid, Medicare, HIV Drug Assistance Program (HDAP), and private health insurance options, including those offered through the MA Health Connector and Comprehensive Health Insurance Initiative (CHII).

Providers in New Hampshire are similarly expected to be knowledgeable about resources available through NH state agencies and programs, such as the NH DHHS, including NH CARE, New Hampshire Health Protection Program, and Division of Family Assistance. Applicants for this service area must describe how staff will remain informed and up-to-date about policy and programmatic changes and how services will be made accessible to clients.

Applicants may describe models that provide the Benefits Counseling service component to NMCM teams, including throughout posting, by means of Memoranda of Agreement.

Acuity Assessment

NMCM services are intended to provide case management to low-acuity clients, whereas the MCM service category is intended to provide medical case management to high-acuity patients. BPHC requires that both MCM and NMCM programs develop an acuity assessment to be conducted at intake to determine the level of care needed by the client. If a client is identified as a low-acuity client, then the client may continue to receive services at the program. If a client is identified as a high-acuity client, then the NMCM program must refer client to an internal or partnering MCM program. Assessments should be conducted every six months to determine client's acuity.

STAFFING

Case Managers and Case Manager Supervisors

It is expected that NMCM providers have the credentials, skills, and experience to offer high quality services. Each NMCM service component requires a significant knowledge base and skill set. Applicants are strongly encouraged to determine appropriate qualifications for each position within the NMCM team, and to propose salaries that are commensurate with these qualifications.

NMCM service providers must ensure that staff members have an advanced understanding of issues that will enable them to effectively support clients in coordination with the HIV medical care provider. Subrecipients directly providing benefits counseling must have strong familiarity with state and federal benefits programs including Medicaid, Medicare, Social Security, and Department of Transitional Assistance programs and the associated eligibility criteria and application procedures. Subrecipients

directly

providing housing search and advocacy must have extensive knowledge of local, state, and federal housing resources in the area and associated eligibility criteria and application procedures, Criminal Offender Record Information (CORI) issues and appeals processes, and eviction prevention strategies, including connections to legal services providers.

NMCM administrative and clinical supervisors must actively maintain an understanding of BPHC requirements to fully support staff members who are providing direct services to clients. Administrative supervisors must ensure that the staff they oversee are accessing education, training, mentoring, and technical assistance that help them develop professional knowledge and skills. Proposals with staffing models that include administrative supervisors who have advanced degrees in related fields (i.e., social work, nursing, counseling, etc.) will be favorably considered. All funded NMCM providers will be required to attend BPHC's MCM Training and Capacity Building program's training.

11. OTHER PROFESSIONAL SERVICES

FY 2025 Planning Council Allocation: $82,921
FY 2025 Planning Council Allocation (MAI): $84,831

HRSA DEFINITION AND DESCRIPTION

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 HRSA RWHAP-eligible PLWH 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 HRSA 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.

HRSA PROGRAM GUIDANCE

Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.
See 45 CFR § 75.459

ELIGIBILITY

For FY 2025, BPHC seeks applicants who will demonstrate the ability to provide Other Professional Services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

Providers must be able to make an explicit connection between the legal service and the intended client's HIV care and treatment. They must be able to demonstrate that the service is necessary to improve the client's health outcomes. All applicants must demonstrate their capacity to provide the following service elements:

Consultation

Legal review of a client's case to discuss preparation or escalation of advocacy/representation.

Advocacy/Representation
Staff providing legal counsel to clients on allowable services (above) to ensure stability and improve health outcomes.

STAFFING

All legal counsel services must be performed by trained professional staff. Attorneys must have current licensure and hold certifications through the boards and commissions and Bar Association in the state of Massachusetts. Staff attorneys must be in good standing with the State Bar of Massachusetts. Paralegal staff or other employees must be qualified to hold the position in which they are employed. Non-licensed staff must be supervised by a licensed attorney.

12. PSYCHOSOCIAL SUPPORT

FY 2025 Planning Council Allocation: $986,795
FY 2025 Planning Council Allocation (MAI): $108,638

HRSA DEFINITION AND DESCRIPTION

Psychosocial Support Services provide group or individual support and counseling services to assist eligible PLWHA to address behavioral and physical health concerns. Services may include:

- Bereavement counseling,
- Child abuse and neglect counseling,
- HIV support groups,
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services), and
- Pastoral care/counseling services.

HRSA PROGRAM GUIDANCE

According to HRSA Policy PCN 16-02, funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home Delivered Meals).

ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide Psychosocial Support services for PLWHA within the Boston EMA. In addition, proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

MAI ELIGIBILITY

For FY 2025, BPHC seeks applicants that will demonstrate the ability to provide Psychosocial Support services for PLWHA within the Boston EMA that "address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities (including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders)." [SEC. 2693. ø300ff–121)] Additional consideration for MAI funding will be given to proposals that demonstrate strong cultural awareness, linguistic capacity, and successful engagement strategies for hard-to-reach individuals.

Proposed programs must meet or exceed all Universal Service Standards as well as all additional standards established for the service.

DESCRIPTION OF SERVICES

All applicants must demonstrate their capacity to provide the following service elements:

Individual-Level Support

Individual-level support services are those in which Community Health workers offer emotional support and practical guidance to people living with HIV in drop-in centers, substance use treatment programs, multi- service centers, and/or in non-traditional venues.

Group-Level Support

Group-Level Support involves people living with HIV coming together to share common experiences and challenges of living with HIV/AIDS, exchange information, and provide emotional and practical

support. Program models may incorporate the participation of partners, caregivers, and family members of people living with HIV. Agencies that wish to offer meals with peer support groups do not need to apply separately for Food Services.

STAFFING

Applicants may propose to integrate Psychosocial Support services that accompany Medical Case Management, or Non-Medical Case Management services rendered by community health workers, medical case manager, or other members of an integrated care team.

Note: Community Advisory Boards do not count towards Psychosocial Support activities.

SERVICE MODELS

The Ryan White Part A grant is intended to support the implementation of services rather than the development of programs as Ryan White funds are not intended to be used to supplant or replace state or local HIV funding. The Boston Public Health Commission (BPHC), requires sub-recipients to have established programs with the capacity and infrastructure to implement requested HIV service(s). These HIV services should serve those in greatest need of support and align with the National HIV/AIDS Strategy, Ryan White Legislative Goals, and the EMA HIV Continuum of Care outlined above.

As part of this current procurement, BPHC is promoting the development of an integrated care system. The goal of the integrated care system is to create a robust service delivery system that promotes retention in care by eliminating barriers in accessing medical and supportive services. The integrated care system is composed of two care delivery models: a multi-service model and a collaborative model. Programs should be either composed of an array of Part A services or have formal partnerships with other Part A service providers. Clients should be able to access all service categories funded by BPHC either internally or through an established network or partnership.

Multi-service model

Under this model, programs provide a combination of any Part A services to form a comprehensive HIV program. BPHC is promoting the development of a multidisciplinary team. For instance, a multi-service program can be comprised of medical case management (in clinic-based settings only), non-medical case management, psychosocial support, medical transportation, food bank/home delivered meals, housing, and emergency financial assistance services. A multi-disciplinary team would then be comprised of a nurse case manager providing medication adherence, a community health worker coordinating medical transportation, educating clients on PrEP, etc., an HIV or substance abuse counselor providing individual/group counseling, and a housing specialist providing housing search/advocacy services and distributing emergency financial assistance funds. The program would develop policies and procedures regarding intake and initial assessment process, referral for specific services within the program, and coordination of care among staff.

Collaborative model

Under this model, programs develop formal partnerships with other Part A and HIV service providers to develop a robust and collaborative service model, where clients can seamlessly access a myriad of HIV services. This model is intended for programs located in remote areas within the Boston EMA or for programs without the capacity to provide multiple HIV services within their agency or program. Agencies applying under this model must:

- Develop partnerships with other Part A and HIV service providers, including memoranda of understanding that must be reviewed and signed annually.
- Develop a referral methodology with a referral tool, release forms, outlined referral processes, and follow-up/care coordination processes with scheduled routine collaborative team meetings.
- Develop a resource guide for clients with information for all partnership programs.
- Develop and perform trainings to inform other Part A service providers on how to access their program services.

PROPOSAL REVIEW AND SELECTION

SUBMISSION PROCESS

The proposal and all legal documentation must be received by BPHC no later than **Friday, December 13, 2024, 5:00 PM.**
THERE WILL BE NO EXCEPTIONS TO THE 5:00 PM DEADLINE.

Collaborative Proposals
BPHC strongly encourages organizations to submit joint applications for services. Such proposals should emphasize shared resources/services coordinated between agencies capturing the expertise of each partner to achieve and maintain viral suppression through a seamless system of care. The lead agency must be specified in the proposal and a representative of the lead organization must sign the application cover page and submit a comprehensive abstract. The proposal must specify which organization will act as the fiscal agent. If there are differences in target dates for the implementation of services provided by multiple agencies, this should be noted in the work plan. Each entity must submit a letter of agreement acknowledging participation in the collaboration and submitted as an attachment to this application. BPHC will verify the arrangements by examining the supporting documents.

Funding will *not* be allowed for positions dedicated to interagency program administration of collaborative proposals unless the administration is incorporated as part of the job description of direct care staff funded through the RFP.

PROPOSAL REVIEW AND SELECTION PROCESS

An objective, external, independent review committee including community representatives, consumers, providers, and former members of the Boston EMA Planning Council will review proposals and make recommendations for funding to the Recipient (BPHC). During the review process, applicants may be required to present additional information in written and/or oral form for clarification.

Proposals will be reviewed and scored based on the evaluation criteria in *Section II*. Scores assigned by reviewers will affect recommendations for funding as well as the level of an applicant's grant award. Individual applications are not compared to other applications; each is evaluated independently in terms of its responsiveness to application questions. Following an internal review process, notification of the award decisions will be mailed to each applicant.

BPHC reserves the right, prior to executing a contract, to:

- Negotiate the applicant's Annual Scope of Work,
- Require the applicant to make linkages with other agencies/programs accepted under this RFP,
- Negotiate award amounts and fund with conditions of award

CONTRACT REQUIREMENTS

All funded agencies must sign a contract with BPHC to become subrecipients of the Ryan White A grant, and receive funding including, but not limited to, provisions detailed here.

LEGAL ISSUES

The contract will include provisions relating to termination issues, confidentiality, non-discrimination and civil rights, liability (including professional liability insurance for appropriate staff and general liability coverage), the status of funded subrecipients as independent parties, publication, political activity, ownership of equipment, conflict of interest, choice of law, force majeure, notice, assignment and subcontracting, severability, waivers, amendments and modifications, and any other provisions deemed necessary or appropriate by BPHC or as may be required by the federal funding source.

HIPAA

BPHC is a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA). As such, all subrecipients are required to complete a Business Associate Agreement assuring that they will comply with all HIPAA regulations relating to Protected Health Information.

REPORTING

Thorough program reporting and monitoring are essential to evaluate the effectiveness of Ryan White funds in addressing the unmet service needs of PLWHA. HRSA also considers this information when allocating Ryan White funds to the EMA. All funded subrecipients will be required to collect all data necessary to complete any required reporting as mandated by HRSA including The Ryan White HIV Program Services Report. Failure to produce timely and adequate reports will jeopardize the subrecipient's funding during the current award period, as well as its eligibility or consideration for future funding.

By submitting an application for Ryan White funds, a subrecipient agrees to adhere to the following if funded:

Annual Scope of Work Submission

All funded subrecipients will be required to submit an annual provider scope of work. The Scopes will help funded subrecipients create evidence-driven and performance-based targets at the start of each fiscal year. The Scope shall address:

- The subrecipient’s plan/vision;
- Any subrecipient and/or program successes and challenges;
- The structure of the subrecipient’s board of directors and consumer advisory board;
- Proposed program model/description;
- Proposed client demographics, service delivery, and service utilization goals;
- Any interagency coordination;
- Any relevant Part A policies and procedures (including all appropriate attachments);
- Procedure(s) to ensure that all data are submitted to BPHC as required;
- General personnel and any cultural and linguistic competency of program staff; and quality management and/or evaluation of services.

E2Boston Data Entry System
All subrecipients are required to use *E2Boston* to track Ryan White client utilization and services, as well as for mandatory report submission. Subrecipients can manually enter data into the system at monthly intervals or develop a data import process for higher volume subrecipients. *E2Boston* acts as a one-step portal where funded subrecipients can satisfy HRSA reporting requirements, including the Ryan White Services Report, as well as track client utilizations, demographic info, and health outcomes. This system allows subrecipients to track service volume and outcomes over time. Subrecipients are expected to review data including, but not limited to, HIV viral load to ensure viral suppression is being achieved and maintained.

Subrecipients will be provided technical assistance for uploading data and extracting data to produce all required reports in *E2Boston*.

Client-Level Data Submission
All required data are considered a program deliverable. Invoices will not be processed for payment if the required data have not been received. Funded subrecipients will be required to submit client-level demographic quarterly, utilization data monthly, and client-level outcome data semi-annually.

All Scope targets will be stored in the E2Boston database. Client Demographics Table will be replaced by reports generated in E2Boston. Data elements for quarterly reports can also be accessed as tables in E2Boston created based on clients' age, housing status, gender, and or other identifying factors. Please see *Section II* of the application for more information on additional features for data importing from agency electronic health/medical records not E2Boston.

Client Outcome Reporting
Client-level outcome reports capture health and quality of life outcomes for PLWHA and must be submitted using E2Boston. Some of these indicators are required by HRSA. All funded subrecipients will be required to provide at a minimum the following information in *E2Boston*:

- Laboratory Results/Measures: CD4, viral load
- Primary medical care engagement: adherence to HIV medication, adverse effects of medication
- Medical Case Management status: access to support network
- Health and Quality of Life Measures: housing status, mental health status
- Linkage to Care data

Client outcomes must be entered within 6 months of service initiation. Successful RFP applicants will be provided with detailed instructions on the use of E2Boston and outcomes reporting.

MONITORING

Each funded subrecipient shall participate in no less than one (1) site visit per calendar year. Site visits include a review of both fiscal and programmatic compliances with the grant. Key personnel involved in the implementation of the Scope of Services at any and all locations where funded activities occur, as well as appropriate records, must be available for site visits. BPHC may request additional information at any time. BPHC may provide specific formats for submitting reports that the funded subrecipient will be required to follow.

BPHC will provide technical assistance to subrecipients of Ryan White funds regarding reporting and monitoring requirements as well as programmatic concerns as necessary.

SUBRECIPIENT EXPECTATIONS

The following items of program importance that subrecipients are expected to uphold throughout the duration of their contract period:

- To become part of the comprehensive plan for organization and delivery of HIV-related health and support services developed by the Boston HIV Services Planning Council.
- To participate in ongoing meetings or task forces aimed to increase, enhance and maintain coordination and collaboration among HIV-related health and support service providers.
- To participate in an HIV community-based continuum of care, to the extent such a continuum exists, with a community-based continuum of care defined as described in the RFP.
- To assure that Ryan White Part A grant funds will be used in compliance with all funding restrictions as described in the RFP.
- To ensure that no funding will be requested from BPHC that could be reimbursed through Medicaid, private insurance or another funding source.

RECORD MAINTENANCE

Funded subrecipients will be expected to keep records of their activities related to BPHC-funded projects and services. Funded subrecipients must permit BPHC, the federal funding source, or its agents, access to those records, including fiscal records and client records, where appropriate while maintaining respect for clients' rights to privacy and confidentiality (*see Appendix D*).

SCOPE OF SERVICES AND BUDGET

Funded subrecipients negotiate a contract with BPHC which includes a Scope of Services specifying the service(s) to be provided; target population, geographic area; expected number and demographic composition of clients to be served; expected number of service units to be provided; price per unit (when applicable); an approved budget containing Direct Care Costs and Indirect or Administrative Costs contracts or units of service for unit rate contracts; and all conditions that apply to the

contract. Subrecipients are expected to meet the goals and objectives set in the Scope of Services and are limited to expend resources according to their budget. Failure of a selected applicant to satisfactorily negotiate a contract within a reasonable time may result in the applicant forfeiting its award.

CONTRACT PAYMENTS
BPHC will pay subrecipients for allowable expenses, within 30 days of receipt, after review and approval of invoices.

FISCAL SUBMISSION
All funded subrecipients will be required to submit monthly invoices detailing the allowable costs during the previous calendar month (*see Attachment 1*).

CONTRACT AMENDMENTS
BPHC has the option of amending contracts throughout the funding cycle based on program performance, fiscal expenditure, and other contracted requirements.

CONTRACT EXTENSIONS/RENEWALS
Funded subrecipients with programs that are not up for bid may receive a contract extension/renewal for future fiscal years. This renewal is subject to the availability of federal funding and program performance, contract compliance, and compatibility of the service to the Boston EMA HIV Services Planning Council's Comprehensive Plan.

MISCELLANEOUS

COORDINATION WITH FUNDERS OF HIV SERVICES

In order to provide the best use of limited Ryan White funding and resources, BPHC may coordinate with other funders of HIV services, including Ryan White Recipients, HRSA, CDC, MDPH, NH DHHS, and other entities to ensure that service categories funded under this procurement are coordinated and do not duplicate or supplant other funding streams that applicant agencies may already receive. Subrecipients that receive existing funding for services proposed for this RFP must demonstrate through the proposals, and potential contract negotiations if successfully funded, about how Part A funds are being used. BPHC reserves the right to share information submitted within proposals and during the review process that would aid in efforts to reduce duplication of funding or services across funders.

RFP CANCELLATION

BPHC may, during the proposal review process or at any time prior to award, cancel this request for proposals or reject all proposals if it is determined that this is in the best interest of BPHC or in the best interest of the Boston EMA to take such action. Notice of the cancellation will be made to applicants or potential applicants, as appropriate.

INSUFFICIENT RESPONSE

BPHC may, upon determining that no satisfactory proposals have been received for a particular service, decide to provide those services directly; negotiate with a successful applicant for a related service to include this particular service as part of the service package; or may re-bid for those particular services.

DEBRIEFING

After the issuance of award letters, any applicant may request an opportunity to:
examine the RFP Process and Award Report:

- Discuss with BPHC staff the reasons for the award decisions; and/or
- Hear recommendations that could make proposals stronger in the future.

Such requests must be submitted in writing via email within thirty (30) days of the notification of award to:

Melanie Lopez
Director of Client Services
ryanwhiteservices@bphc.org

Frantzsou Balthazar- Toussaint
Direct of Subrecipient Compliance
IDBFiscal@bphc.org

Once applicants have submitted letters, BPHC will try to accommodate such requests within a reasonable time. Such requests are not considered appeals. Award decisions are final.

APPEALS

Applicants may appeal only the following acceptable claims:

- Funding decisions inconsistent with the Part A Boston EMA HIV Services Planning Council's comprehensive plan, prioritization of service categories, or service allocation decisions;
- Deviations from the established contracting and awards process, or deviations from the established process for any subsequent changes to the selection of contractors or awards;
- Access to information not made available in the RFP document resulted in an unfair competitive process; or

- Award/funding decisions by the review team or BPHC reflect a conflict of interest.

All appeals must be addressed to the Director of the Infectious Disease Bureau (or designee). The written intent to grieve and the request for resolution must be received no later than three (3) business days after the public notice of the award decision.

BPHC will notify the grievant within three (3) business days if the written grievance is outside of the scope of the procedures and is determined not eligible to initiate these procedures.

BPHC will investigate the grievance with its support staff taking all steps necessary and appropriate to gather relevant information. BPHC will work to facilitate a resolution of the grievance that is mutually agreeable by both parties. BPHC shall schedule a Resolution Meeting with the grievant at the convenience of both parties with regard to the meeting date/time and location. The date for the Resolution Meeting shall be within six (6) business days after the receipt of the grievance by BPHC. While all attempts will be made to schedule the resolution meeting at the convenience of the grievant, the grievant is expected to be available to meet with BPHC staff within six (6) business days of the receipt of the grievance at BPHC office located at 1010 Massachusetts Avenue, 2nd Floor Boston. Failure to attend such a meeting will be considered a waiver of the grievance. In an extreme emergency, the parties may agree to reschedule. Rescheduling must be by written agreement and within five (5) business days. A resolution shall be made by BPHC within three (3) business days after the resolution meeting.

RESOURCES

TITLE XXVI – HIV HEALTH CARE SERVICES PROGRAM (RYAN WHITE LEGISLATION)
https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf

1) HEALTH RESOURCES & SERVICE ADMINISTRATION:
a) RYAN WHITE HIV/AIDS PROGRAM PART A MANUAL (HRSA)- 2023
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

b) POLICY NOTICES AND PROGRAM LETTERS
https://ryanwhite.hrsa.gov/grants/policy-notices

c) NATIONAL MONITORING STANDARDS: FISCAL STANDARDS
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/fiscal-monitoring-part.pdf

d) NATIONAL MONITORING STANDARDS: PROGRAM STANDARDS
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/universal-monitoring-partab.pdf

e) NATIONAL MONITORING STANDARDS: UNIVERSAL STANDARDS
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf

2) RYAN WHITE SERVICES DIVISION
a) FY24 PROVIDER MANUAL & FY24 STANDARDS OF CARE
https://mailchi.mp/bphc.org/updates_and_annoucements-9451902?e=f689dd2003

OTHER RESOURCES
3) Target HIV: Tools for HRSA's Ryan White HIV/AIDS Program: https://targethiv.org/

4) HIV.Gov: https://www.hiv.gov/

5) AIDSinfo: https://aidsinfo.nih.gov/

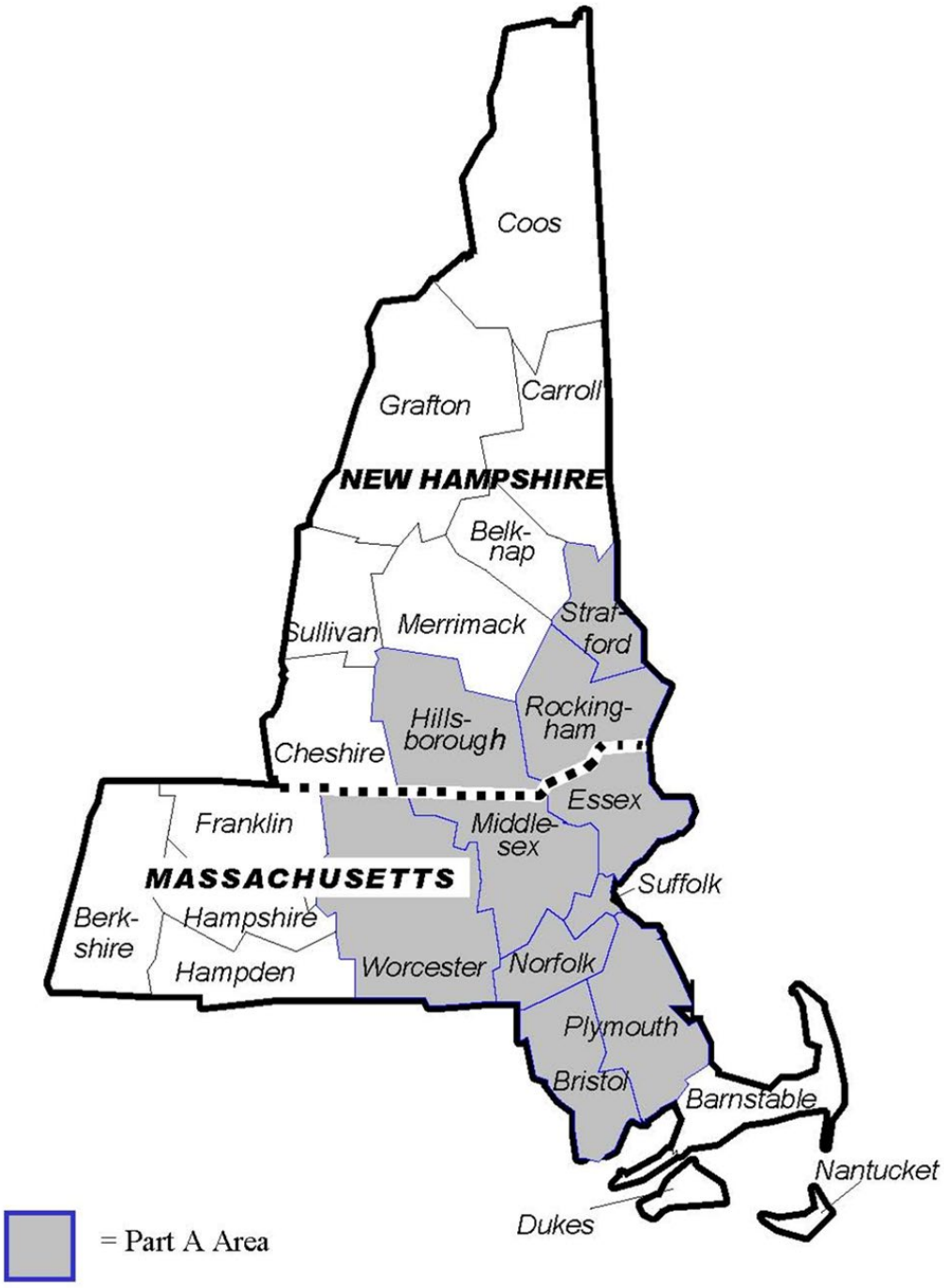
6) HRSA – About Ryan White: https://hab.hrsa.gov/about-ryan-white-hivaids-program

APPLICATION AND INSTRUCTIONS

The application may be found in ***SECTION II: Application*** along with detailed instructions and explanations of requirements. Please include the name of the agency and the service category on each page of the application. In addition, please label each response clearly. The label should include the section of the application (e.g. F. Service Description) and the question number.

APPENDICES

APPENDIX A: BOSTON ELIGIBLE METROPOLITAN AREA (EMA) MAP



APPENDIX B: DEMOGRAPHIC PROFILE OF THE BOSTON EMA

HIV Incidence - Newly Diagnosed (MA+NH)			
Demographic Group/Exposure Category	**2021**	**2022**	**2023**
	#	#	#
Race/Ethnicity			
White, not Hispanic	153	123	137
Black, not Hispanic	141	143	187
Hispanic/Latino	108	127	149
API/Unknown	18	18	23
Place of birth			
(1)US	235	197	245
(2)PR/US depen	9	13	8
(3)Non-US	173	200	239
(4) Unknown	3	1	4
Sex			
Male	291	298	367
Female	129	113	129
Gender Idenity			
Cisgender	396	406	487
Transgender	4	5	9
Age			
00-12	1	0	1
13-19	7	4	12
20-29	87	115	121
30-39	147	146	170
40-49	91	67	92
50-59	53	47	61
60-69	30	23	29
70+	4	9	10
Exposure Category			
Men who have sex with men	148	146	204
Injection drug users	78	44	37
Men who have sex with men and inject drugs	10	16	14
Heterosexuals	30	22	24
Other	4	0	4
Presumed HTSX	48	58	84
NIR	102	125	129
Total	420	411	496

SOURCE: MDPH

PLWH (HIV/AIDS) Prevalence (MA)			
Demographic Group/Exposure Category	**2021**	**2022**	**2023**
	#	#	#
Race/Ethnicity			
White, not Hispanic	7491	7380	7343
Black, not Hispanic	6459	6562	6727
Hispanic/Latino	4944	5062	5283
API	516	533	557
Other/Unknown	264	271	273
Place of birth			
(1)US	11486	11358	11319
(2)PR/US depen	1541	1493	1480
(3)Non-US	6647	6957	7384
Sex			
Male	13923	13995	14224
Female	5751	5813	5959
Gender Idenity			
Cisgender	19578	19710	20080
Transgender	96	98	103
Age			
00-12	22	21	20
13-19	46	40	43
20-29	949	903	889
30-39	2840	2912	3018
40-49	3490	3460	3471
50-59	6217	5887	5585
60-69	4693	4944	5285
70+	1417	1641	1872
Exposure Category			
Men who have sex with men	7714	7756	7916
Injection drug users	2862	2782	2717
Men who have sex with men and inject drugs	760	748	737
Heterosexuals	2708	2695	2718
Other	397	400	399
Presumed HTSX	1860	1924	2030
NIR	3373	3503	3666
Total	19674	19808	20183

PLWH (HIV/AIDS) Prevalence (NH) as of September 2023	
County	**PLWHA**
Hillsborough	678
Rockingham	255
Strafford	144
Total EMA	1077

SOURCE: NHDHHS

HIV Incidence - Newly Diagnosed (MA+NH)			
Socioeconomic Data of Part A Clients			
Income			
Equal to or below FPL	70	89	119
101-200% FPL	19	23	17
201-300% FPL	18	18	18
301-400% FPL	9	9	2
401-500% FPL	2	2	3
Greater than 500% FPL	2	0	0
Unknown	0	0	0
Insurance Status			
Private	5	13	6
Medicare	4	11	3
Medicaid	60	58	90
Other/Multiple[3]	45	49	51
No insurance/Unreported	6	10	9
Housing/Living Arrangement			
Permanent	94	97	95
Temporary/Transitional[4]	19	31	56
Institutional setting[5]	1	3	1
Homeless/Place not meant for human habitation	5	9	4
Languages			
English	53	54	46
Spanish	19	34	57
Haitian Creole	11	14	27
Portuguese	18	13	14
Other[6]/Unknown	19	26	15
Total	119	141	159

SOURCE: E2Boston

PLWH (HIV/AIDS) Prevalence (MA)			
Socioeconomic Data of Part A Clients			
Income			
Equal to or below FPL	2887	2858	2910
101-200% FPL	1135	1149	1128
201-300% FPL	579	628	652
301-400% FPL	298	322	301
401-500% FPL	122	121	111
Greater than 500% FPL	35	30	18
Unknown	138	74	45
Insurance Status			
Private	420	451	445
Medicare	492	487	475
Medicaid	2172	2099	2125
Other/Multiple[3]	1852	1937	1904
No insurance/Unreported	258	208	216
Housing/Living Arrangement			
Permanent	4258	4331	4242
Temporary/Transitional[4]	579	565	628
Institutional setting[5]	53	47	51
Homeless/Place not meant for human habitation	212	186	178
Languages			
English	2666	2604	2525
Spanish	912	933	986
Haitian Creole	256	277	306
Portuguese	316	359	345
Other[6]/Unknown	1044	1009	1003
Total	5194	5182	5165

SOURCE: E2Boston

[1]Includes Native Hawaiian, American Indian, and more than one race
[2]Includes modes of transmission other than those listed above (e.g., perinatal transmission), and those with no identified risk.
[3]Includes Indian Health Service, VA and other military health care, Commonwealth Care, Health Safety Net, Other Public Insurance, and more than one
[4]Includes temporarily staying with a friend or family member
[5]Includes residential substance use treatment, psychiatric facilities, and incarceration
[6]Includes French, Crioulo (Cape Verdean), S.E. Asian Languages, and American Sign Language

APPENDIX C: HIV CARE CONTINUUM

The HIV Care Continuum (HCC)[1], also known as the HIV treatment cascade, describes the stages of HIV medical care necessary for persons living with HIV (PLWHA) to progress from initial HIV diagnosis to viral suppression defined as having <200 copies/mL, undetectable levels. This is critically important to understand, as current antiretroviral therapy (ART) regimens not only preserve the health of PLWHA but when undetectable viral load is achieved, there is effectively no risk of sexual HIV transmission.

The HCC is a visual diagram that shows the proportion of PLWHA in a specific catchment area who are engaged at each stage of the continuum.

HIV testing and diagnosis
The HIV care continuum begins with a diagnosis of HIV infection. People who don't know they are infected are not accessing the care and treatment they need to stay healthy. They can also unknowingly pass the virus on to others. CDC recommends that all adolescents and adults be tested for HIV infection at least once, and that persons at increased risk for HIV infection be tested at least annually.

The HIV Diagnosis Care Continuum begins with the total number of people known to be infected with HIV (i.e., diagnosed) and is commonly referred to simply as the HIV Care Continuum (HCC). However, this number does not include those persons infected but unaware of their disease status. When the total population is used, the treatment cascade is referred to as the HIV Prevalent Case Care Continuum.

Getting and staying in medical care
It is important to be connected to an HIV healthcare provider who can offer treatment and prevention counseling to help individuals stay as healthy as possible and prevent passing HIV on to others.

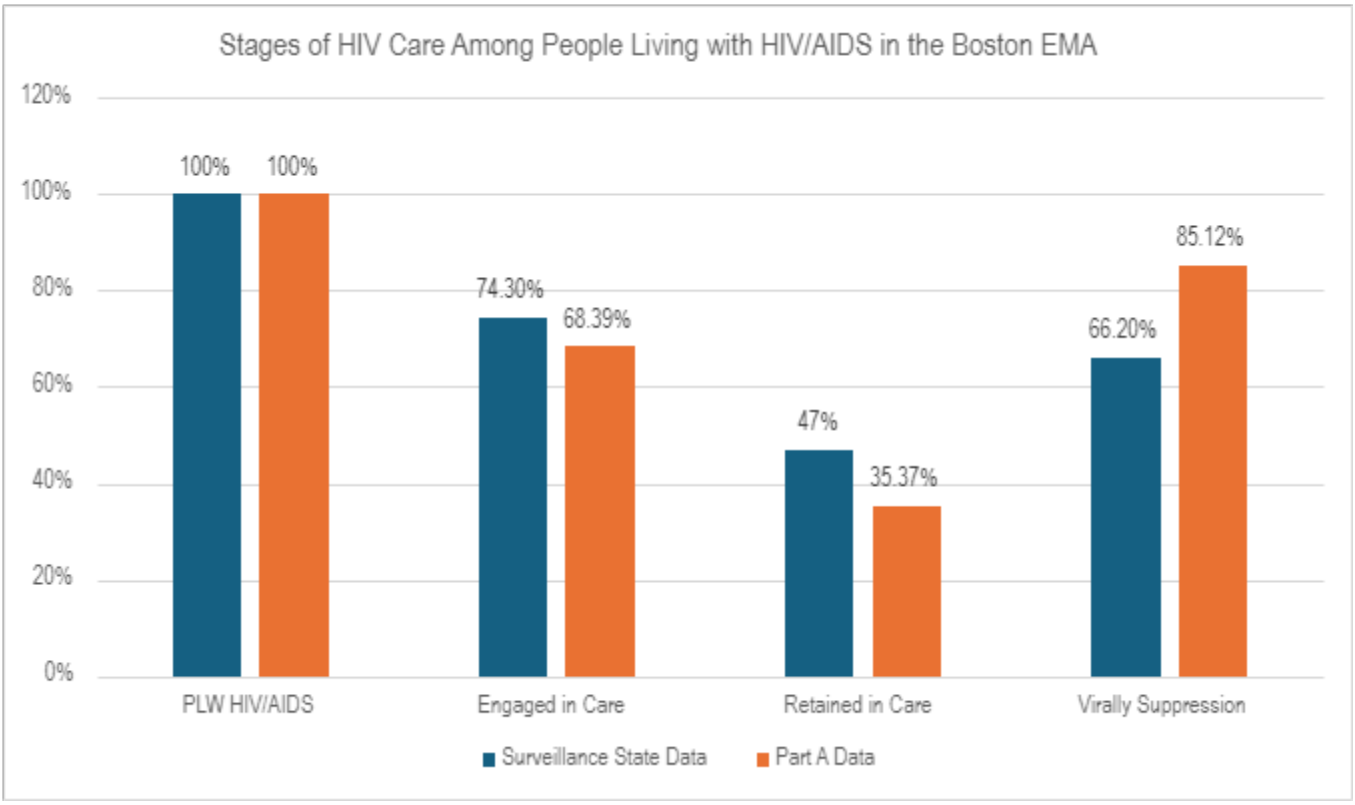
Getting on antiretroviral therapy
Antiretrovirals are used to prevent HIV from replicating (making more copies of itself). Antiretroviral therapy (ART), the recommended treatment for HIV infection, involves using a combination of three or more antiretroviral drugs from at least two different HIV drug classes every day to control the virus. Federal clinical guidelines recommend that all PLWHA receive treatment regardless of their CD4 cell count or viral load. Treatment with ART can help people with HIV live longer, healthier lives, and has been shown to reduce sexual transmission of HIV by 96 percent.

Achieving viral suppression

By taking ART regularly, individuals can achieve viral suppression, meaning a very low level of HIV in their blood not detectable by tests, but are not cured. Lowering the viral burden in the body with medicines can help individuals stay healthy, live longer, and greatly reduce the chances of passing HIV on to others.

According to HIV.gov[1], 65/100 diagnosed with HIV were virally suppressed in 2020 and of the 1.2 million individuals living with HIV in 2019, 57% had achieved viral suppression. In comparison, the Boston EMA viral suppression rate is 90.36%[2], as recorded through E2Boston.

Boston EMA HIV Care Continuum



Stages of HIV Care Among People Living with HIV/AIDS in the Boston EMA

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[1] "What is the HIV Care Continuum?" hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum
2 E2Boston Cloud Base Database System | RDE Developers

RYAN WHITE HIV/AIDS TREATMENT
EXTENSION ACT PART A

Fiscal and Program Rules FY 2024

Ryan White Services Division
Boston Public Health Commission
1010 Massachusetts Avenue, 2nd Floor

Fiscal Rules FY 25 – 37

All Part A contracted subrecipients are expected to expend 100% of their award in accordance with all federal, local, and BPHC policies. The Recipient will only reimburse subrecipients for deliverables that have been mutually agreed on (see Scope of Services and Budget) and upon receipt of appropriate invoices and back-up documentation. If the subrecipient wishes to revise the Scope of Services or allowable costs, they must submit a proposal to revise the Scope and/or Budget. In addition, it may be required that a subrecipient audit be submitted. Failure to meet these expectations may result in suspension or termination of your contract.

A. Invoicing

General Information

1. A standard invoice, including the approved budget, must be submitted. Part A payments are based on the approved budget, and only line-item budgeted expenses will be reimbursed.

2. BPHC only accepts electronic invoices; handwritten invoices are not acceptable.

3. Each funded service must have its invoices signed by a program representative or a contract specialist before submission to BPHC.

4. Invoices are submitted monthly, within 30 days of the month's end. Each day after that will be considered late, therefore non-compliant. The final invoice for each fiscal year must be submitted no later than March 30 of the new fiscal year.

5. Invoices must represent actual monthly expenses. Invoices without the required information or documentation (including required data and reports) will be rejected for resubmission.

6. If no contracted activities occurred in a given month, and there are no billing costs, the subrecipient must submit an invoice with a $0 monthly total for that month.

7. Any revised or supplemental invoices are to be clearly labeled as such by including the word “Revised” or “Supplemental” within the “Invoice Number” notation. Retroactive billing may only occur when the expense is not billed to another funding source. Documentation of bills to other funding sources may be required.

8. Monthly invoices containing all the required information will be paid within 30 days of receipt. Invoices are sent to IDBinvoices@bphc.org. When submitting invoices, please also copy the contract manager for your agency.

9. For additional questions regarding the submission of invoices, contact your fiscal coordinator.

Personnel Expense and Other Direct Care Cost Invoicing

1. Appropriate supporting documents for monthly staff expenses invoices include:
    a. Payroll registers and labor distribution reports
    b. Copies of vendor invoices
    c. Canceled checks
    d. Copies of reimbursement/voucher forms

2. The budget on the invoice must illustrate the approved contract budget. The monthly costs are charged on the invoice "Amount this Invoice" column. The "Cumulative Billing" column must correctly report the year-to-date billed amounts.

3. The fringe rate must be the internally audited fringe rate. Verification of this rate is subject to audit. 50 (Fringe is defined as government-mandated and employer-selected employee benefits including Social Security, unemployment, workers' and disability compensation, retirement programs, and health insurance).

4. The following are requirements for invoices submitted for the purchase of client-related travel, meals/food, and other client consumables in the "Other Direct Care Cost" line items on any Part A budget:
    a. Itemized receipts must include the merchant or provider name, service received, or specific item purchased date of service, and amount of expense.
    b. Itemized list indicating the client codes of those receiving the service and service utilization information (i.e., the dates and quantity of service provided to each client).

5. These services require the collection of documentation at the time of billing for all (but not limited to) the following 'Other Direct Care Cost' line items:
    • Bus and subway fare
    • Commuter rail
    • Contracted services rides
    • Food provided with client activities (e.g., Psychosocial Support group meals)
    • The Ride tickets
    • Taxi vouchers
    • Volunteer mileage
    • Emergency Financial Assistance

Sample of the itemized list for transportation and housing assistance services:

Sample of the itemized list for **transportation** and **housing assistance** services:

Client Code/ UCI	*Date*	*Unit of Service*	*Amount*	*Vendor*
MAR0609547899/ RSCR0609542	03/04/24	Rental Start Up	$300	Century 21
MAR0609547899/ RSCR0609542	03/12/24	One-Way Taxi to Medical Appointment	$22.50	Boston Taxi

Please note:
    • RW funds cannot be paid directly to clients.
    • Do not use Housing Rental Assistance for mortgage payments.
    • The itemized lists for Transportation must include to and from the location and the purpose of

the trip.

1. The following must be submitted before billing for a consultant the first time:
    a. A resume and list of qualifications for the consultant.
    b. A detailed description of the services/activities performed by the consultant.
    c. The consultant's last name must be indicated on the invoice cover sheet when the invoice is submitted.

2. Contracts can only include an "Indirect" line item (capped at 10%) if the subrecipient has a certified HHS-negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certification of Indirect Costs, or if the subrecipient has never before had a negotiated indirect cost rate, the subrecipient may utilize the de minimis rate of 10%* or less. In all circumstances, the subrecipient must adhere to a 10% cap on administrative expenses, which may include but are not limited to indirect costs. Budgets must include itemized administrative expenses.

3. Vehicle mileage is reimbursed at a per-mile rate not to exceed the Internal Revenue Service's standard mileage rate, which is currently $0.67* per mile.

4. Travel outside of the EMA is an allowable expense under Part A, especially when the travel is for necessary training, which may be held in various parts of the state or the country. Prior approval from the HIV/AIDS Services Division for travel outside of the EMA may be required under certain circumstances. No international travel is allowed under this grant. Please note: Tipping related to travel expenses (clients or staff travel) is an allowable expense, but only if it is part of a subrecipient's policies and procedures. The Federal limits for tips are capped at 15%.

**Subject to change during the fiscal year. Pending reduction approval from HHS.*

B. Fiscal Compliance

Under the Ryan White HIV/AIDS Treatment Modernization Act of 2009, there are significant penalties to the EMA if there are unexpended dollars at the end of the fiscal year. Therefore, all programs must spend 100% of their contracted award. Contract expenses, as shown on invoices, are reviewed each quarter of the fiscal year. The subrecipient is informed after the first quarter, in writing, of any underbilling. Any contract underbilled through the second quarter may be reduced. If the underspending is due to a late start, the reduction to the subrecipient award is equal to the amount of year-to-date spending. If the underspending is an ongoing concern, the reduction of the award will equal year-to-date expenditures and the projected underspending to year-end. RWS will reallocate funds to other subrecipient budgets following the Ryan White Planning Council's service priorities. Reallocations within individual categories and the resulting contract revisions do not require Planning Council approval.

BPHC will only pay for expenses properly presented and documented on invoices. The subrecipient may be held in "non-compliance" at the end of each month if the invoicing requirements are not met. Non-compliance includes non-submission of invoices or late invoices. RWS will lift non-compliance once all the submission meets requirements.

Contract spending may vary by up to 25% monthly within a budget line item if the total amount billed does not exceed the budget's maximum obligation for the fiscal year. For example, if you project a charge of $500 to a monthly salary (annual salary of $6,000), you may spend $625 within that line per month (therefore, it cannot exceed $7,500 annually) with sufficient backup. For other direct care costs, e.g., if you are budgeted for a $1,000 office supply line for the year, you may spend up to $1,250 within that line (you may bill

this in one month, or it may be divided among several months). Overspending of the contract will not be paid. Any changes over the 25% leeway may require prior approval for re-budgeting from the HIV/AIDS Services Division in the form of a budget revision request. Contract funding for a Part A fiscal year may not be used in a subsequent fiscal year. Fiscal years are discrete; the funding is separate and is not "carried over." This does not prevent the purchasing of supplies during one fiscal year that may be used in the current fiscal year and subsequent fiscal years.

C. Audits

Each subrecipient must provide a copy of its most recent Financial Statement Audit report with Management Letter to BPHC for BPHC to execute its subaward. Additionally, any subrecipient that expends $750,000.00 or more in federal awards during its fiscal year ($1,000,000.00 or more effective October 1, 2024) must also provide a copy of its most recent Single Audit report to BPHC for BPHC to execute its subaward. All Financial Statement Audit reports with Management Letters and all Single Audits must be provided electronically to auditreports@bphc.org . If any report cannot be provided electronically, contact RyanWhiteServices@bphc.org and IDBFiscal@bphc.org to receive alternative submission guidance.

If electronic submission is impossible, send paper audits to:

Post-Award Grants Manager
Boston Public Health Commission
1010 Massachusetts Ave, 6th Floor
Boston, MA 02118

BPHC reserves the unilateral right to require subrecipients found to have one or more significant deficiencies and/or material weaknesses in their Financial Statement Audit report and/or Single Audit report (if applicable) to provide additional invoice backup documentation in select future invoice submissions. If BPHC determines a subrecipient has significant findings in their financial statement and/or single audit, BPHC will include language in the Special Terms and Conditions section of the subaward stating they are required to submit backup documentation with their invoices and a more detailed review will be performed during annual site visit monitoring.

D. Budget Revisions

1. Contract budgets are not changed without the approval of the Boston Public Health Commission. A revised budget request in the same format as the contract budget and accompanied by lne-item explanations of proposed revisions is required. If the budget revision does not match the most up to date contract budget, it will be returned to the subrecipient. Complete instructions are available under the budget revision section of the manual.
2. Subrecipient requests to revise contract budgets are sent via email to the subrecipient's assigned contract manager and copy ryanwhiteservices@bphc.org.

3. Budget revision requests must include the following: (1) a budget revision form with a

detailed explanation for the requested changes; (2) a current budget with the proposed changes made in the same format; and (3) any relevant back up documentation to validate the changes e.g payroll changes, new hire paperwork, etc.

4. Generally, appropriate requests are those which propose using different means to accomplish the specific program features which were approved and detailed in the original Scope of Services. In general, adding new line items is not an acceptable request. With prior approval, Subrecipients are allowed to shift funds between existing line items due to evolving service needs.

5. Budget revisions will **not** be accepted after **December 15**. If December 15 falls on a weekend, the Ryan White Services team honors the deadline to be the next Monday. Revisions submitted after this deadline will only be considered to fill vacant positions and for legal name and position title changes.

6. Initial appeals of denied budget revision requests are made, in writing, to your contract manager and the Director of Subrecipient Compliance.

E. Additional Funding Restrictions

1. Grant funds may not be used to supplant or replace current state or local HIV-related funding.

2. Funds may not be used to purchase or improve land or to purchase, construct, or make permanent improvement to any building except for minor remodeling.

3. Funds may not be used to make payments to recipients of services.

4. Recipients of grant funds must participate in a community-based continuum of care. A continuum of care is defined as:
A comprehensive continuum of care includes primary medical care for the treatment of HIV infection that is consistent with Public Health Service guidelines. Such care must include access to antiretrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections as well as combination antiretroviral therapies. Comprehensive HIV care also must include access to substance-abuse treatment, mental-health treatment, oral health, and home health or hospice services. In addition, this continuum of care should include supportive services that enable individuals to access and remain in primary medical care as well as other health or supportive services that promote health and enhance quality of life.

5. ***The aggregate total of Part A Subrecipients administrative expenditures shall not exceed 10% of the aggregate total of Part A funds awarded to the Subrecipients (without regard to whether any of these Subrecipients expend more or less than 10% for such expenses).*** For the purposes of the 10% aggregate cost cap, administrative activities include:

   · Usual and recognized overhead activities, including rent, utilities, and facility costs.
   · Costs of management oversight of specific programs funded under this title, including program coordination; clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; and computer hardware/software not directly related to patient care.

6. If a particular service is available under the state Medicaid Plan, the political subdivision involved must either provide the service directly or enter into an agreement with a public or private entity to provide the service. The Subrecipient providing the service must enter into a participation agreement under the state Medicaid Plan and must be qualified to receive payment under the state Medicaid Plan.

7. Funds may not be used to provide items or services for which payment already has been made, or reasonably can be expected to be made, by third-party payers, including Medicaid, Medicare, and/or other state or local entitlement programs, prepaid health plans, or private insurance. It is therefore incumbent upon Subrecipients of Part A funds to assure that eligible individuals are expeditiously enrolled in Medicaid and that Part A funds are not used to pay for any Medicaid-covered services for Medicaid-eligible PLWHA. Part A Subrecipients are subject to audit on this and other restrictions on

use of funds.

8. If Part A Subrecipient charges for services, it must do so on a sliding-fee schedule that is made available to the public. The intent is to establish a ceiling on the amount of charges to Part A service recipients. A simple application that requests information on the annual gross salary of the individual/family should provide the baseline by which the caps on fees will be established

Individual/Family Annual Gross Income and Total Allowable Annual Charges

Individual/Family Annual Gross Income	Total Allowable Annual Charges
Equal to or below the official poverty line	No charges permitted
101 to 200 percent above the official poverty line	5% or less of gross income
201 to 300 percent above the official poverty line	7% or less of gross income
More than 300 percent above the official poverty line	10% or less of gross income

9. Funds are to be used in a manner consistent with current and future program policies developed for Part A regarding allowable categories of services and eligibility for services. Please review all current HRSA/HAB and BPHC program policies.

10 All travel must be within the EMA and directly related to the services provided under the specific contract.

11. Funds may not be used for outreach programs that have HIV prevention education as their exclusive purpose or broad-scope awareness activities about HIV services that target the general public.

12. Additional conditions are outlined in the annual Provider Manual.

Reporting

Reporting, as outlined below, is a mandatory deliverable within the Ryan White Part A Annual Scopes of Services. Failure to produce timely and adequate reports may jeopardize the subrecipient's eligibility or consideration for funding in subsequent years.

1. The subrecipient must maintain a record of participating Part A clients in BPHC's E2Boston System. Subrecipients must register all clients in E2Boston, including information regarding their demographics, exposure category, diagnostic information, housing and insurance status, and medical history. Every month, the subrecipient must enter utilization data for each client, including units of service delivered, dates of service, and the number of units. Units are defined in the Ryan White Service Standards.

2. The subrecipient must complete an Outcome Measurement Report to quantify and track the health of each client served. A "Client Clock" monitors outcomes reporting on a cycle during which the client received services. Subrecipients must also ensure that all other client-specific timelines, Eligibility, Reassessments etc., are met throughout the year through the use of E2Boston.

3. Subrecipients must notify Ryan White Services Division (RWS) of updates to their annual work plan.

4. Subrecipients must report changes to primary Ryan White Part A program contacts to their assigned contract manager as soon as possible, and no later than, within a month of the change.

5. If a subrecipient receives Medical or Non-Medical Case Management and Psychosocial Support Services, they must report changes in their case management and psychosocial support staff to the Case Management Training Program, and Psychosocial Support training and ensure the staff attends the required trainings. Subrecipients should contact their contract manager with any questions.

6. All subrecipients must complete the Ryan White Services Report (RSR) each calendar year. RWS will release additional information in January before the RSR submission. *Additional information available on the TargetHIV website.*

7. All subrecipients must comply with the requirements detailed in the Ryan White Service Standards.

Monitoring

BPHC or other entities on behalf of BPHC will conduct site visits. The Subrecipient will receive no less than one (1) site visit during the period of performance (March 1 through February 28 of each year). Site visits include a review of both fiscal and programmatic documentation. Key personnel involved in implementing the Scope of Services at all locations where funded activities occur should be available for site visits and make all appropriate records available to BPHC staff.

Additional information may be requested before, at, or after the site visit(s). The Subrecipient will have a reasonable time to produce such information. The Subrecipient will also receive reasonable notice prior to each site visit. The BPHC will take care to schedule site visits at such times as may be mutually agreed upon, so long as such scheduling does not result in delay, in which case the Boston Public Health Commission shall specify a date and time for the site visit. The BPHC also has the right to visit at a time of its choosing and without advance notice.

Income Eligibility

The Subrecipient will be expected to comply with the **Financial Eligibility Policy for Ryan White Services** which requires funded providers to screen PEOPLE LIVING WITH HIVclients for income eligibility, based on a threshold of 500% of the Federal Poverty Level (FPL) as determined by the U.S. Department of Health and Human Services (HHS). When applicable the Subrecipient will also adhere to the **Ryan White Services Sliding Fee Scale Policies**, as indicated by BPHC.

2024

FY 2024 Service Standards Ryan White Part A Boston EMA

BOSTON PUBLIC HEALTH COMMISSION
RYAN WHITE SERVICES DIVISION

Table of Contents

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) provides funding for Ryan White Services in the Boston EMA. The contents of this manual are those of the Boston Public Health Commission Ryan White Services Division, developed to ensure compliance with the legislative and programmatic requirements of the RWHAP Part A program, and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Service Standards

Section I: Universal Standards

The Service Standards are the minimum requirements that programs are expected to meet when providing HIV services funded by Ryan White Part A. Subrecipients are encouraged to exceed these standards. The Service Standards ensure that Subrecipients best meet the needs of their clients and are consumer-focused in the design and implementation of services. **Service Standards apply equally to services provided in-person and via telehealth.** The objective of the Universal Service Standards is to help achieve the goals of each service type by ensuring that programs:

- Have policies and procedures in place to protect clients' rights and ensure quality of care for both in person and telehealth services;
- Have Emergency Preparedness and Response Policies and Procedures services in place to guide service provision during emergencies such as the COVID-19 Public Health Emergency;
- Provide clients with access to the highest quality services through experienced, trained, and when appropriate, licensed staff;
- Provide services that are culturally and linguistically appropriate;
- Meet federal and state requirements regarding safety, sanitation, access, public health, and infection control;
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of grievance review and advocacy;
- Comprehensively inform clients of services, establish client eligibility, and collect and store client information through an established process;
- Effectively assess client needs and encourage informed and active client participation;
- Address client needs effectively through coordination of care with appropriate subrecipients and referrals to needed services;
- Are accessible to all people living with HIV in the designated 10 counties that constitute the Boston EMA;

1.0 **Eligibility, Insurance & Recertification**

RWS Description:

Ryan White legislation requires that individuals receiving services through Ryan White Part A funding must have a diagnosis of HIV, reside in the Boston EMA and be income eligible as detailed in this section. Subrecipients must demonstrate that all other funding sources available are fully exhausted before Ryan White funds are utilized. Funded subrecipients are responsible for screening clients for eligibility for Medicaid (MassHealth and NH Medicaid), other third-party insurance, and other funding sources as appropriate. Ryan White Part A funds may not be used for any item or service "for which payment has been made or can reasonably be expected to be made" by another payment source [1].

Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements: PCN 16-02
https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1302clienteligibility.pdf

Standard	**Measure**
1.1 Eligibility Subrecipients must establish eligibility of clients at intake and recertify clients for eligibility annually. Activities include: • Complete an intake *(**See Standard 2.1 -Intake)*** • Screen patients for eligibility • Maintain intake and eligibility documentation in client file and E2Boston	Record of eligibility in the client file and E2Boston, including: • Client name, home address and mailing address • Documentation of HIV Status • Proof of Boston EMA residency • Verification of income eligibility • Documentation of health insurance
1.2 HIV Status Documentation required for the initial eligibility determination includes: • Diagnosis letter signed by a licensed physician on MD Stationary • Lab Test Results • Positive test result from ELISA and/or Western Blot HIV test (not anonymous)	Record of HIV status evident in client's file and E2Boston Providers only need to collect this documentation one time at the initial determination of eligibility and do not need to update after initial submission.
1.3 Income Must have an income of 500% or less of the most current FPL. Documentation includes at least one of the following: • State/Federal Tax Return • Current pay stub • Bank statement indicating direct deposited income • Disability award letter • Self-employment affidavit • Support affidavit • MassHealth Verification (i.e. screen shot of EHR face sheet or Virtual Gateway verification) • NH Medicaid Verification • HDAP approval letter	Client files and E2Boston must have updated documentation to verify income eligibility once a year.
1.4 Boston EMA Residency	Client files and E2Boston must have updated documentation

	to verify EMA residency once a year.

Standard	**Measure**
The client must reside within the 10 counties of the Boston EMA. Documentation includes at least one: • Utility Bill • Lease/Mortgage Statement • Support affidavit • Letter from Shelter • MassHealth Verification (i.e. screen shot of HER face sheet or Virtual Gateway verification)	
1.5 Health Insurance The client must be enrolled, or in the process of enrolling into health insurance. Documentation includes at least one of the following: • Insurance Verification document • Recent Explanation of Benefits • Recent Explanation of Payment • Recent Premium Bill • MassHealth letter • Patient Medical Information (PMI) Form • HDAP approval letter	Client files and E2Boston must have updated documentation to verify insurance coverage for eligibility once a year.
1.6 Recertification Providers must recertify Ryan White Part A eligibility every 12 months.	All eligibility documentation must be collected at least once annually.
1.7 Electronic Tracking of Eligibility Status Providers must enter client eligibility status and upload the required back-up documentation, as listed above in **Standards 1.1-1.6**, for all clients into E2Boston.	Record of subrecipient tracking client eligibility status and back-up documentation in E2Boston
1.8 Eligibility Data Sharing When Subrecipients refer a client to another Part A subrecipient in the Boston EMA, they must: 1. Ensure eligibility status is current and that eligibility documentation is uploaded into E2Boston (either full documentation or self-attestation, whichever is most recent);	Records in E2Boston of subrecipient uploading consent forms and sharing eligibility data with Part A Subrecipients/services

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

Standard	Measure
2. Upload completed client **Consent to Receive Services Form,** which is subrecipient specific and collected at intake (**see Standard 2.1-Intake**); and 3. Complete and upload the **Consent and Authorization to Share Information Form** developed for the Data Sharing and Eligibility Module. Please note that if the client declines to authorize sharing, the information cannot be shared, and each subrecipient will have to verify eligibility through a separate process or through another method of information sharing. 4. The purpose of this **Consent and Authorization to Share Information Form** is to allow the sharing of individual data when seeking services at two or more Subrecipients; or to revoke sharing of data if the client no longer wishes to share eligibility data with those Subrecipients. **This consent will remain valid for one year or until revoked by the client.** If the client wishes to revoke their consent form, they must do so in writing and must resubmit the consent form indicating their revocation to an subrecipient within the system.	

2.0 **Intake, Discharge, Transition & Case Closure**

RWS Description:

Providers are responsible for educating clients of their rights and responsibilities, confidentiality policies, and informing clients of the subrecipient's grievance policy for all Ryan White Part A funded services at the time of intake and on an annual basis thereafter. Additionally, all clients must receive a general needs assessment 14 business days from the initial engagement. If a client is discharged or a case closure occurs, the provider must reasonably attempt to contact the client to inform the client of their pending discharge/case closure.

Standard	**Measure**
2.1 Intake Within 14 business days of initial contact with a client, the subrecipient must perform an intake. Intakes must include the collection of identifying information and the review and completion of the Confidentiality Policy and Client Grievance Procedures forms, the Client Rights and Responsibilities form, and the Consent to Receive Services form. Intakes must also include an assessment of client language needs and a plan to ensure client access to all services, materials, and communication in the client's preferred language. Subrecipients must work with clients to determine the best mode of service delivery for the client, based on client preference, at the time of scheduling appointments. **If the subrecipient does not offer in-person services in a given period due to an emergency, staff will work to support client access to services via alternative service modalities.*	Record of intake completed, including all required components, within 14 business days of initial contact of the client
2.2 Confidentiality Policy Confidentiality Policy and Release of Information will be discussed and signed.	Confidentiality Policy and Release of Information policy reviewed, signed, and dated by client annually, and placed in file
2.3 Rights and Responsibilities and Grievance Policy Client will be informed of their rights and responsibilities and the grievance procedures. A copy will be provided to the client on an annual basis for review and the subrecipient will post the grievance policy publicly to ensure that all clients are aware of how to file a grievance.	Rights and Responsibilities and Grievance policy signed and dated by client annually, and placed in file
2.4 Discharging, Transferring or Case Closures The subrecipient must have policies and procedures in place to discharge, transition and/or close cases when the client: • Relocates out of the service area • Has no direct program contact in the past 6 months (becomes inactive) despite provider contact to engage in care. • No longer needs the service • Discontinues from the services • Is incarcerated for a year or longer	Record of discharge, transition and/or case closure within the client file Written policies and procedures about discharge process on file at the subrecipient Record of at least 3 attempts to contact clients before discharge and to communicate about case closures

• Exhibits threatening behavior that prevents the provision of a service or that prohibits another client from receiving services. • Has passed away Policies and procedures for discharge must include at least three (3) attempts to contact the client before discharge. The subrecipient must inform the client of discharge with information about how they can access services in the future if needed.	

3.0 **Client Retention, Re-Engagement, and Linkage and Access to Care**

RWS Description:

Ryan White Part A funded Subrecipients must have policies and procedures in place to promote client retention, re- engagement, and linkage to care. Funded Subrecipients should also have policies and procedures in place that ensure clients' access to care.

Standard	**Measure**
3.1 Client Retention and Re-Engagement Policies and Procedures Providers will develop and implement policies and procedures to support retention of clients in care and re-engagement if they fall out of care. These should include staff protocols to follow-up with clients to determine and mitigate barriers to accessing services and continuity of care. **Note:** Service delivery models that are medium to large group interventions must assess participation.	Written policies on file at the provider's subrecipient Record of at least 3 attempts to re-engage clients that fall out of care Record of reason for individual falling out of care
3.2 Linkage to Care (referrals) Providers must provide appropriate referrals to resources and services to fully address client needs and mitigate barriers to continuity of care. Providers must follow **Standard 1.8** regarding eligibility data sharing, when making referrals to another Part A funded service in the Boston EMA	Documentation of referrals evident in client file that correspond to identified client needs Records in E2Boston of subrecipient uploading consent forms and sharing eligibility data with Part A Subrecipients/services in Boston EMA
3.3 Accessibility of Facility Services at provider subrecipient are accessible to clients according to ADA requirements, and are equipped with accessible elevators, ramps, TTY, etc.	Observations made by RWS staff upon visiting provider sites
3.4 Accessibility of Setting to Income-eligible Individuals Services delivered by provider are available in settings that are readily accessible to income-eligible individuals.	Observations made by RWS staff upon visiting provider sites Interviews with staff
3.5 Service Delivery Space Provider makes deliberate effort to ensure that facilities are welcoming and comfortable to the populations served. Provider must configure physical spaces and establish/follow protocols that ensure services provided are private, whether in-person or telehealth modalities.	Observations made by RWS staff upon visiting provider sites Interviews with staff
3.6 Collection & Utilization of Client Input Provider develops and implements policies and procedures to regularly obtain client input and utilize the input to inform service delivery.	Written policies and procedures on file at the provider's subrecipient Documentation that indicates utilization of client input Interviews with staff

Standard	Measure
3.7 Refusal of Services Policies & Procedures Provider has policies and procedures in place for clients who have been or who refuse a service, along with appropriate documentation thereof.	Written policies and procedures on file at the provider's subrecipient Documentation of each client that has been refused a service with the rational for refusal
3.8 Engagement of Income-eligible Clients Provider conducts specific activities and/or maintains promotional materials that are used to engage income-eligible clients and to promote awareness of Ryan White services.	Interviews with staff Review of the percentage of provider's clients that are income-eligible

4.0 **Staff Credentials, Training, & Supervision**

RWS Description:

Providers are responsible for delineating administrative and direct service costs in accordance with PCN 15-01. The licensure, credentials, experience and training of staff on Ryan White Part A budgets must reflect requirements of the service-specific standards set forth within this document or reflect internal policies set by the subrecipient. Generally, all staff must meet minimal qualifications to administer and/or deliver services, including:

- Provision of appropriate care to people living with HIV
- Documentation of the services delivered to people living with HIV
- Administration of the required fiscal or programmatic components of service delivery

Furthermore, all direct service staff must receive administrative supervision. Administrative supervision addresses issues relating to staffing, policy, distribution of vouchers, scheduling, training, quality improvement activities and overall communication. One hour per month of clinical supervision must be provided for Health Education & Risk Reduction, Non-Medical Case Management, Medical Case Management and Psychosocial Support direct staff. Clinical supervision can occur in a group or individual setting and must be provided by a third part who is not associated with the funded Ryan White Part A service. The clinical supervisor may be employed by the subrecipient but must be impartial to the service(s) provided.

All Subrecipients must maximize third-party billing for staff with the proper credentials and/or licensure to bill third-party payers for services render to clients by credentialed and/or licensed staff member. They must bill for the services rendered to clients. Income earned from the Ryan White program must be tracked and reported to RWS.

Source: PCN 15 – 01 Treatment of Cost Under the 10% Administrative Cost
https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1501.pdf

Source: PCN 11 - 04 Use of Ryan White HIV Program Funding for Staff Training
https://hab.hrsa.gov/sites/default/files/hab/Global/habpl1104.pdf

Standard	**Measure**
4.1 Training and Onboarding The subrecipient must develop and execute training according to PCN 11-04.	Training and onboarding materials on file
4.2 Cultural Competency The subrecipient's recruitment, onboarding and training policies must reflect an intention to provide accessible services in a manner most appropriate to the population served.	The subrecipient will provide documentation, in the form of a cultural competency policy or other document, that reflects a commitment to provide appropriate services to the service population.
4.3 Supervision of Funded Services All staff will receive relevant supervision of services rendered under the funded service category.	The supervision structure will be defined and documented in a policy by the subrecipient.

5.0 **Staff Safety Standards**

RWS Description:

The Ryan White Part A funded subrecipient must establish policies and procedures to protect the physical safety of staff and clients, both on-site and in the community. Ryan White Part A staff must be protected and supported by a subrecipient to ensure crises can be properly managed and de-escalation protocols are in place to prevent harm to both clients and staff members.

Standard	**Measure**
5.1 Safety Protocol for Staff and Clients Subrecipient must have a safety policy/protocol that is reviewed and signed by Part A staff members.	A written safety policy/protocol is on file at the subrecipient location
5.2 Anti-bullying, Discrimination, and Sexual Harassment The subrecipient must have a policy with language that protects staff and clients, regardless of how they identify their gender, sexual orientation and ethnicity.	A written safety policy/protocol for anti-bullying, discrimination and sexual harassment is on file at the subrecipient location
5.3 Staff Safety on Community and Home Visits The subrecipient must have policies in place to ensure the safety of staff and clients during community and home-visits.	A written safety policy/protocol for staff safety on community and home visits is on file at the subrecipient location
5.4 Protocol for Incident Reporting The subrecipient must have policies in place for staff to report incidents. Policies must contain a timeframe of when the incident occurred to when the follow up report is expected to happen. *The specific timeframe would have to be determined by the Subrecipients, with adherence to BPHC's grievance and incident policy.	A written safety policy/protocol for incident reporting is on file at the subrecipient location

6.0 **File Maintenance & Data Security**

RWS Description:

The Ryan White Part A funded subrecipient must meet all mandatory file maintenance and data security requirements and standards. These requirements include the documentation of engagements between the client and provider both in- person and via telehealth, policies pertaining to electronic and paper file security, and quality assurance activities related to the maintenance of files and the archiving of files.

Standard	**Measure**
6.1 File Security Client records maintained by the subrecipient must be locked or password protected. Access to records must be limited to relevant staff.	Security measures observed during monitoring activities
6.2 Data Entry Data entry and reporting requirements for recipient and HRSA are completed according to the required schedule and with complete and accurate data.	Verified through E2Boston
6.3 Archiving Subrecipient will archive client files that meets the minimum requirements in accordance with state, federal, and other legal regulations.	Policy must be documented and may include use of Iron Mountain or other archive systems

Section II: Core Medical Services

HRSA Definition:

Essential, direct, health care services for HIV care.

7.0 **ADAP**

HRSA Description:

The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide
U.S. Food and Drug Administration (FDA)-approved medications to income-eligible clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV. HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:

- HRSA RWHAP Parts A, C and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.
- See PCN 07-03: The Use of Ryan White HIV Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services
- See PCN 18-01: Clarifications Regarding the use of Ryan White HIV Program Funds for Health Care Coverage Premium and Cost Sharing Assistance
- See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Ensure that all people living with HIV have access to and are able to adhere to HIV and other prescribed medical regimens.

Objective*:* Ease the financial burden of medical costs for people living with HIV by providing financial assistance for prescription medication.

Standard	**Measure**
7.1 Pricing ADAP subrecipient has a process to secure best prices available for all medications, including 340b pricing or better and a policy to determine the cost effectiveness of purchasing insurance for clients.	Record of medication purchases and policy to determine cost effectiveness of purchasing insurance

7.2 File Maintenance ADAP files will be kept in accordance with Massachusetts and/or New Hampshire code of regulations.	Files compliant upon RWS staff review during monitoring visits

Standard	Measure
7.3 Formulary ADAP services must include a medication formulary that meets the minimum requirements of all approved classes of medications according to HHS treatment guidelines.	A record of the medication formulary on file

8.0 **Medical Case Management**

HRSA Description:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes variety of encounters including face-to-face, phone contact, or via another form of telehealth, etc.

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 activities 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:

- Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.
- Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Engage clients who face significant challenges to enter and maintain treatment for their HIV.

Objective: Assess client needs and develop a Comprehensive Treatment Plan (CTP) that provides guidance and assistance in improving health care outcomes for people living with HIV.

Standard	**Measure**
8.1 Medical Case Management Needs Assessment A client needs assessment must be completed within 30 days of intake and include a wide range of topics to identify the client needs and address potential barriers to	Record of needs assessment in client files completed 30 days after the completion of the intake

Standard	Measure
retention in care. The following topics, at minimum, should be assessed: • Healthcare • Mental Health • Transportation • Health Education & Risk Reduction • Sexual Health Assessment • Legal • Support systems • Nutrition • Housing • Insurance	
8.2 Medical Case Management Reassessment of Needs A reassessment of needs must be completed every six months from the previous completed assessment. The reassessment can be adapted to reflect a more narrow focus than the initial assessment based on the clients ongoing needs.	Record of reassessment completed six months after the previous assessment in the client file
8.3 Comprehensive Treatment Plan (CTP) Medical case management staff must develop a medically oriented Comprehensive Treatment Plan with a client-centered approach that is informed by the client needs assessment. The Comprehensive Treatment Plan must be updated every six months, or more often as needed.	Record of the Comprehensive Treatment Plan completed within six months, or less, from the initial or previous comprehensive service plan
8.4 Client Monitoring The provider must continuously monitor the efficacy of the Comprehensive Treatment Plan (CTP). This includes the ongoing assessment of adherence to the Comprehensive Treatment Plan.	Record of regular contact with client within client's file to monitor progress with the CTP
8.5 Treatment Adherence Screening Medical case management staff must routinely perform treatment adherence screenings to ensure adherence to medication.	Record of treatment adherence screening within client files
8.6 Coordination of Care Medical case management staff must coordinate services being provided to the client. Activities may include, but are not limited to: • Scheduling medical and/or behavioral health appointments. • Ordering labs • Providing referrals • Completing supported referrals • Case conferences	Record of services detailed and maintained within client files Completed Authorization Forms for communication with external Subrecipients in accordance with HIPAA Written Referral Policies and Procedures on file at the subrecipient

Standard	Measure
Coordination of care must be appropriate to the client's needs, as identified by the Needs Assessment and/or the comprehensive service plan. These activities must be tracked. Coordinating care with external Subrecipients requires the consent of the client. Consent must be obtained in accordance with state and federal code of regulation.	
8.7 Clinical Supervision Medical case management staff must receive at least one hour of clinical supervision per month.	Record of medical case management staff attendance in clinical supervision
8.8 Caseload Case load determination should be based on client characteristics and the intensity of case management activities.	Written policy on file and procedures for staffing ratios

9.0 **Medical Nutrition Therapy**

HRSA Description:

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

Program Guidance:

- All activities 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. Activities not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.
- See also Foodbank/Home Delivered Meals

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Optimize immunity, reduce weight loss and nutritional deficiencies, and improve the overall wellbeing for people living with HIV.

Objective: Identify and treat nutritional deficiencies in people living with HIV through the provision of medical nutrition therapy which includes nutritional counseling and the prescription of dietary regimens by a physician or licensed nutritionist or registered dietician.

Standard	**Measure**
9.1 Medical Provider Referral Clients receiving services under the MNT service category must be referred by a medical provider.	Record of medical provider referral in client file
9.2 Nutrition Assessment, Screening and Dietary Evaluation A licensed nutritionist or registered dietician must perform a nutritional assessment, screening or evaluation of the dietary needs of the client.	Record of an assessment, screening and/or dietary evaluation in clients file
9.3 Nutritional Plan A nutritional plan must be developed in accordance with the nutritional assessment and screening. The nutritional plan must include (but not limited to) the following items: • Recommend services and course of MNT to be provided, including types and amounts of nutritional supplements and food. • The signature of the referring medical provider and each registered dietician who rendered services.	Record of nutritional plan in client file Record that nutritional plan is updated every six months in client file

Standard	Measure
• Date of the initiation and/or termination of MNT services • Recommendations for follow-up • Planned number and frequency of sessions The nutritional plan must be updated every six months.	
9.4 Food and/or Nutritional Supplements Food and nutritional supplements can be provided to the client based on the nutritional plan completed by the registered dietician or licensed nutritionist.	Record of food and nutritional supplements provided to the client
9.5 Nutrition education and/or counseling All clients receiving a food and/or supplement for the first time will receive appropriate education/counseling. This must include written information regarding the health benefits of the prescribed nutritional plan and recommended strategies to promote adherence to the nutritional plan.	Record of nutritional education and/or counseling in client file
9.6 Provider Licensure Services must be provided by a nutritionist or registered dietician.	Record of licenses and credentials maintained in employees Human Resources file

10.0 **Oral Health Services**

HRSA Description:

Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Prevent and control oral and craniofacial diseases, conditions, and injuries, and improve access to preventive services and dental care for eligible people living with HIV.

Objective: Increase awareness of the importance of oral health to overall health and well-being, increase the acceptance and adoption of effective preventive interventions and reduce disparities in access to effective preventive and dental treatment services. (Healthy People 2020).

Standard	**Measure**
10.1 Clinical Decisions and Treatment Guidelines Dental providers must provide oral health care in accordance with HIV treatment guidelines released by state and federal regulatory bodies. Additionally, clinical decisions must be supported by the American Dental Association Dental Practice Parameters.	Written policies and procedures that reflect the most up- to-date treatment guidelines and American Dental Association Dental Practice Parameters
10.2 Contractor Licensure All dental staff must have appropriate license, credentials and expertise to administer oral health care.	Record of licenses and credentials maintained by the dental provider and submitted to the program for review
10.3 Leadership Training The program director must have training experience in clinical aspects of oral hygiene, dental treatment planning and dental care	Record of demonstrated experience within personnel files
10.4 Wait List Policy The program must have a policy to manage a wait list for eligible RWHAP, Part A clients.	Written wait list policy on file
10.5 Appeal Process The program must have a process in place in the event a client's treatment plan is not approved and the client wishes to appeal the denial of the treatment plan. The client must be informed of the appeals process upon denial.	Written policy and procedures on file at the subrecipient Record that appeal forms are accessible to the clients
10.6 Contractor Recruitment & Training The program must routinely recruit and train dental providers to ensure gaps in service delivery are addressed.	Written policies and procedures to recruit and onboard dental providers on file at the subrecipient

10.7 Treatment Plan A treatment plan must be developed by contracted dental providers that is based on an initial examination of	Contracted dental providers must record treatment plans in client file

Standard	Measure
the client. Treatment plans must be reviewed and approved by the dental program director.	
10.8 Treatment Plan Review and Update The treatment plan must be reviewed and updated routinely by the dental provider and/or dental program director.	Record of treatment plan review and update in client files

Section III: Support Services

HRSA Definition:

Services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV.

11.0 **Emergency Financial Assistance**

HRSA Description:

Emergency Financial Assistance provides limited one- time or short-term payments to assist a RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: paying for utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an subrecipient or through a voucher program.

Program Guidance:

- Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category.
- Direct cash payments to clients are not permitted.
- If EFA is being used for emergency housing support, mortgage and rental deposits are not permitted and all other housing services standards must also be followed.
- Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Assist clients with meeting a short-term urgent need for an item or service that is essential to their HIV care and treatment. Services and items could include, but are not limited to, the following:

- Utilities (*may include household utilities including gas, electricity, propane, water, and all required fees*)
- Housing (*may include as rent or temporary shelter and recommended to not exceed no more than 6 months. EFA can only be used if HOPWA assistance is not available*)
- Food (i.e., groceries or food vouchers)
- Transportation (Taxi vouchers, Uber Health, Lyft Health, bus passes)
- Prescription medication assistance (i.e., short term or one-time assistance for any medication and associated dispensing fee as a result or component of a primary medical visit, and not to exceed a 30-day supply)
- Other RWHAP allowable costs needed to improve health outcomes
- Vision Care to pay the cost of corrective prescription eye wear for eligible clients

SUBRECIPIENTS FUNDED FOR EFA MUST BE ABLE TO MAKE AN EXPLICIT CONNECTION BETWEEN ANY SERVICE SUPPORTED WITH EFA FUNDS AND THE INTENDED CLIENT'S HIV CARE AND TREATMENT, OR CARE-GIVING RELATIONSHIP TO A PERSON LIVING WITH HIV.

Unallowable EFA Expenses:

- Mortgage payments and security deposits for rental housing
- Direct cash payments to clients
- Clothing
- Court fees
- Maintenance expense (tires, repairs, etc.) of a privately-owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees, towing or impound fees, excise tax. This restriction does not apply to vehicle operated by organizations for program purposes.
- Local or state personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and burial expenses

Objective: Subrecipients funded for EFA will assess client's emergency needs related to food security, housing, utilities, transportation and cost of medication, as well as provide appropriate assistance.

Standard	**Measure**
11.1 Emergency Financial Assistance Assessment An assessment of the presenting emergency must be completed by the provider. Providers must demonstrate an urgent need resulting in client's inability to pay their utility bills or prescriptions without financial assistance for essential items or services necessary to improve health outcomes. For example, demonstrated need may be demonstrated by, but not limited to the following: • A significant increase in bills that prevents a client from addressing both basic needs to maintain positive health outcomes and the increased cost of bill(s) • A recent decrease in income • Unexpected event that hinders ability to meet housing, utility, food or medication need • High unexpected expenses on essential items • Client is unable to provide for basic needs and shelter • A failure to provide EFA will result in danger to the physical health of client or dependent children • Other emergency needs as deemed appropriate by the provider	Record of assessment of need evident in the client file
11.2 Tracking EFA The provider must track dispersal of EFA. This includes creating a tracking system that clearly indicates the date of distribution, client code and type of EFA provided.	Development of a tracking mechanism and a record of EFA provision within 3 business days of approval of request

Standard	Measure
11.3 EFA Voucher All payments made on behalf of clients or vouchers distributed, of any kind, to clients, is/are consider an EFA Voucher. EFA Vouchers ***cannot be provided in the form of direct cash payment*** to a client. The use of store cards/gift cards with the Mastercard/Visa/American Express logo are ***considered cash payments and cannot be distributed*** to the client. Payments must be made to another subrecipient or vendor.	Program/subrecipient fiscal records
11.4 Payer Anonymity Payment for assistance made to service providers will protect client confidentiality by ensuring the source of payment cannot be identified as a HIV service provider. • Use of checks, envelopes, credit cards, or other forms of payment that de-identify subrecipient as an HIV/AIDS provider.	Program/subrecipient fiscal records
11.5 Processing EFA All completed requests for assistance shall be approved or denied within three (3) business days.	Record of EFA voucher distributed within three (3) business days of application
11.6 Drugs/Medication Drugs distributed under EFA must be included in the State formulary.	Record of the type of medication purchased, the cost of the medication, and evidence that the medication is/are on the approved formulary
11.7 Third-Party Payer & Benefits Applications The provider must take steps to enroll the client into HDAP, MassHealth, housing supports, SNAP, or other third party to continue support for the client.	Record of third-party payer applications/screenings maintained in the client files
11.8 Multiple Funding Sources & Payor of Last Resort All other sources of funds for Housing, Food Bank/Home Delivered meals or other funding sources that can address the urgent needs of the client, must be exhausted prior to the use of EFA. Prior approval can be made for special circumstances.	Program/subrecipient fiscal records Documentation of referrals to other resources as relevant

11.9 EFA Limitation & Subrecipient Controls The delivery of EFA must be a one-time or short-term financial support. The provider must have approved policies for the distribution of EFA and only distribute EFA in accordance with the defined terms within the scope of services. The policy must detail fiscal and programmatic controls and define the limitations of each type of EFA awarded to provide. Policies must include: • EFA Duration & Frequency • Limitation of Unit Distribution	Written policy, approved by RWS, on file

Standard	Measure
NOTE: RWS recommends Subrecipients awarded with EFA to narrow the definition of emergency for each type of EFA service.	

12.0 **Food Bank/Home Delivered Meals**

HRSA Description:

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 HRSA RWHAP.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Prevent hunger and malnutrition among people living with HIV.

Objective: Improve access to food sources and to improve nutrition for people living with HIV with identified food security needs.

Standard	**Measure**
12.1 Documenting Service Delivery The subrecipient must document the provision of food items, hot meals, food vouchers and/or allowable non-food items. Documentation must include: • Service provided • Amount of food, vouchers, and/or non-food items distributed • Number of clients served • Date of services	Record of service delivery in the client file
12.2 Food Safety The subrecipient must meet all requirements of the local and state health department for food handling and storage.	Record of certifications and licenses on file
12.3 Subrecipient Drivers All drivers delivering meals must hold a valid driver's license and automobile insurance consistent with state minimum requirements.	Personnel files of paid and volunteer drivers contain documents indicating valid driver's licenses

13.0 **Housing**

HRSA Description:

Housing provides transitional, short- term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, and fees associated with these activities.

Program Guidance:

- HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.
- HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.
- Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Assist a client to gain or maintain medical care by reducing the barriers to permanent shelter and provide linkages to permanent housing.

Objective: Eligible clients will receive assistance in the form of individual sessions with a housing search advocate, or in the form of financial assistance, within the parameters listed below.

Standard	**Measure**
14.1 Rental Assistance Services Subrecipients funded to provide rental assistance services must have policies that define: • Use of funds • Maximum/minimum financial assistance a client can have per fiscal year • Reapplication periods • Appeals process The subrecipient must collect documents that validate the housing conditions of the client.	Written policy on file at subrecipient location Lease Agreement/Rental Agreement on file
14.2 Payment Policies The subrecipient must have detailed payment policies and procedures. These policies must include, at minimum,	Written policy on file at subrecipient location

Standard	Measure
• Rental Assistance Application Approval Process • Payment Timelines • Payment Tracking **NOTE:** Ryan White ***cannot pay more*** than the Fair Market Rent as set by the U.S. Department of Housing & Urban Development (HUD). Fair Market Rent amounts are available at: https://www.huduser.gov/portal/datasets/fmr.html Additionally, payments cannot be made for security/rental deposits, mortgage payments and/or directly to clients.	
14.3 Program Application (Rental Assistance) The subrecipient must implement an application for clients to formally request rental assistance. The provider must support all clients in the completion of the application. The program application, at minimum, must include the following: • Date of the Request • Reason for the Request	Record of completed application in client file
14.4 Rejected Applications (Rental Assistance) If an application has been rejected, the client must be informed of the rejection within 24 hours of the decision.	Record of contact (or attempts to contact) in client file
14.5 Payor of Last Resort (Rental Assistance) Alternative rental assistance must be used prior to the use housing rental assistance. Reasonable efforts to explore and apply for alternative rental assistance programs must be performed. **NOTE:** If the clients housing stability will be affected by pending housing application, the use of housing funds to ensure a client is not evicted will be appropriate use of funds.	Record of application and rejection from alternative rental assistance programs
14.6 Housing Search & Advocacy Services Subrecipients funded to provide Housing Search & Advocacy services must have tools in place to track placement of clients and provide referral to services that will lead to permanent housing.	Record of Supported Referral and Client Housing Placement on File
14.7 Housing Assessment The subrecipient must assess the housing needs of the clients. The assessment must include, but not limited to: • Resources • Projected Barriers	Record of assessment in clients file Record of client's budget on file

Standard	Measure
• Strength/Weakness The housing needs assessment must include a detailed client budget that is completed with the provider.	
14.8 Individual Housing Plan Informed by the client's needs assessment, an individual housing plan must detail tenancy goals. If a client receives rental assistance, a client must agree to maintaining communication with housing provider for up to 6 months after rental assistance has been provided.	Record of Individual Housing Plan on file

14.0 **Linguistic Services**

HRSA Description:

Linguistic Services includes interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare or other provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider, client and/or support delivery of HRSA RWHAP-eligible services.

Program Guidance:

Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Address language as a key barrier to access of core medical and support services, and to support the provision of culturally competent, high quality care to Ryan White Part A clients.

Objective: Provide both oral and written interpretation and translation services to Ryan White Part A clients to enable clear communication between provider and client for HIV care and services.

Standard	**Performance Measure**
15.1 Linguistic Assessment Client files will have documented need for linguistic services for interpretation/translation in order to communicate with the healthcare provider and/or other service providers.	Documented evidence of client needs for translation/interpretation in client file
15.2 Responsive and Timely Provision of Service Subrecipients shall provide translation/interpretation services in response to the identified client need in a timely manner.	Record of interpretation and/or translation services provided, including date of service, in client file

15.0 **Medical Transportation**

HRSA Description:

Medical Transportation is the provision of nonemergency transportation 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 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
- Volunteer drivers (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.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Maintain clients connected to core medical and support services that contribute to positive health outcomes.

Objective: Provide allowable transportation resources to eligible clients who otherwise could not access the core and support services to meet medical and support needs.

Standard	**Measure**
16.1 Approved Transportation Methods The use of transportation funds can include; • Volunteer driver system • Purchase/Lease of a Vehicle (Prior Approval required) • Voucher System (for taxi or public transportation etc.) • Rideshare • Uber Health • Lyft Health • 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)	Record of method of transportation in client's file Contract with transportation services Tracking mechanism for the distribution of vouchers (i.e. GATRA Pass or Charlie Cards) Receipts of Rideshare Utilization (i.e. Circulation, Uber, Lyft) Written policies and procedures for a volunteer driver system

Standard	Measure
16.2 Subrecipient Vehicle All vehicles must be registered and properly insured.	Record of Registration and Insurance
16.3 Subrecipient Drivers All drivers transporting clients must hold a valid driver's license and automobile insurance consistent with state minimum requirements. All drivers must be aware of their responsibility in the event of an accident.	Personnel files of paid and volunteer drivers contain documents indicating valid driver's licenses Written Accident policy on file
16.4 Mobility Accommodations and Ride Accessibility All clients must be accommodated under the medical transportation funds. The subrecipient must seek alternative methods for transporting clients who cannot be accommodated with the subrecipient's primary transportation service delivery method.	Record of service delivery in the client file
16.5 Documenting Service Delivery The subrecipient must document transportation of all approved methods. Documentation must include: • Method • Destination/origin • Type of Appointment (Reason) • Date of Service(s) • Units of Service (One Way/Two Way) • Cost A log system must be developed to track transportation services on a monthly basis. **NOTE:** For Volunteer Systems/Subrecipient Vehicle, documentation must include: • Drivers Name • Mileage For Taxi, Public Transportation & Rideshare Services: • Receipts	Record of service delivery in the client file Completed tracking log for transportation services maintained at Subrecipients location Receipts and vouchers maintained at the subrecipient
16.6 Payor of Last Resort Alternative transportation methods (i.e. Medicaid) must be used prior to the use of Medical Transportation funds.	Record of application in client file

16.0 **Non-Medical Case Management**

HRSA Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance with accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM 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, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education- funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes a variety of types encounters including (but not limited to) face-to- face, telehealth, phone contact, etc. 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
- Client-specific advocacy and/or review of utilization of services
- 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:

- NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Enhance access to and retention in essential medical and social support service for people living with HIV. This is a human service approach that supports engagement and retention into medical care.

Objective: Assess client needs and develop an Individual Service Plan (ISP) that provides guidance and assistance in improving access to needed services.

Standard	**Measure**

17.1 Non-Medical Case Management Needs Assessment The assessment must be administered within 30 days of intake and include a wide range of topics to identify the client needs to access medical and support services. The following topics, at minimum, must be assessed: • Healthcare • Mental Health • Transportation • Health Education & Risk Reduction • Legal • Support systems • Nutrition • Housing • Insurance	Record of needs assessment in client file completed 30 days after the completion of the intake

Standard	Measure
• Vocational	
17.2 Non-Medical Case Management Reassessment of Needs A reassessment of needs must be completed every six months from the previous completed assessment. The reassessment can be adapted to reflect a more narrow focus than the initial assessment based on the clients ongoing needs.	Record of reassessment completed six months after the previous assessment in the client file
17.3 Assistance with Benefits Non-medical case managers may assess status of benefits (HDAP, MassHealth, SNAP, WIC, Section 8, PT-1 etc.…) and assist clients in the maintenance of benefits.	Completed benefit applications within client file
17.4 Individual Service Plan Non-Medical Case Management staff must develop an Individual Service Plan (ISP) with a client-centered approach, using SMART goals, that is informed by the client needs assessment. The ISP must be updated at minimum every six months and as needed to respond to changes in client needs.	An Individual Service Plan (ISP) completed within six months, or less, from the initial or previous comprehensive service plan within client file
17.5 Client Monitoring The provider must continuously monitor the efficacy of the individual service plan. This includes the ongoing assessment of key family member needs and the client's personal support system. If circumstances of the client changes, the Individual Service Plan must be adapted to meet changing needs.	Record of regular contact with client within client file
17.6 Caseload Case load determination should be based on client characteristics and the intensity of case management activities.	Written policy on file at subrecipient regarding staffing ratios

17.0 **Other Professional Services (Legal)**

HRSA Description: Other Professional Services (OPS) allows for the provision of professional and consultant services rendered by members of professions licensed and/or qualified to offer such services by local governing authorities.

Under OPS, legal services may be provided to, and/or on behalf of, the HRSA RWHAP-eligible people living with HIV, involving legal matters related to or arising from their HIV disease, including

- Assistance with public benefits
    - Unemployment compensation
    - Social Security Disability Insurance (SSDI)
    - Supplemental Nutrition Assistant Program (SNAP)
    - Supplemental Security Income (SSI)
    - Medicare & Medicaid

- 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 HRSA RWHAP

- Preparation of:
    - Durable Power of Attorney for Healthcare
    - Living will
    - General/Financial Power of Attorney
    - Last Will & Testament or Trust
    - 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:
        - Drafting of wills or delegating powers of attorney
        - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption

- Legal Consultation Services (*not representation*) may also be available in these areas:
        - Debt collection and judgment process
        - Bankruptcy
        - Garnishment

Providers must be able to make an explicit connection between the legal service and the intended client's HIV care and treatment. They must be able demonstrate that the service is necessary to improve the client's health outcomes.

Program Guidance: Legal services exclude criminal defense, OUI, immigration, and class action lawsuits. A class action lawsuit may be considered if related to access to services eligible for funding under the RWHAP.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Provide clients with access to legal services necessary to improve client health outcomes.

Objective: Reduce the effects of HIV discrimination; assist with access to and maintenance of medical care; remove barriers to accessing care, treatment, and services.

Standard	Measure
18.1 Professional Services Staff Qualifications All legal counsel services must be performed by trained professional staff. Attorneys must be current members of the Massachusetts Bar by the Board of Bar Overseers or other similar body in the relevant state. Licensed volunteer attorneys, law students, law school graduates and other legal professionals (acting under the supervision of a member of the bar) may be used to expand program capacity. Paralegal Staff must be supervised by a member of the bar. Paralegal staff or other employees must be qualified to hold the position in which they are employed. Non-licensed staff must be supervised by a licensed attorney.	Certifications and Licenses of all staff funded through Ryan White Part A on file at the subrecipient
18.2 Service Documentation and Legal Assessment The provider must have a written policy that identifies allowable and unallowable legal services funded by Ryan White Part A. Any provider that sub- contracts for Ryan White Part A legal services must ensure the contract includes assurances from the subrecipient providing legal services that it will not bill the provider for legal services that are unallowable under Ryan White Part A legal services. Client file must include a documentation of the need for legal services to support HIV care, treatment and health outcomes. Service agreements will be developed and signed by both the attorney and the client. Documentation for legal services provided must include attorney name, client name, duration of service, rate, type of service provided, (for example, legal consultation, in-person representation of client, developing written legal documents, phone call etc.). The legal matter addressed does not need to be included in this documentation.	Written policy and contracts (if applicable) with assurances regarding billing for services that are unallowable through Ryan White Part A funds on file for RWS staff review Documentation of the need for legal services to support HIV care, treatment and health outcomes included in client file Services agreements, signed by both the attorney and client, in client file Written documentation including the required information about the legal service provided in the client file
18.3 Written Criteria for Services The provider must have an established fee structure, intake process, and case closure policies. Clients must be informed of these criteria before receiving services and related documentation must be included in the client's chart.	Written policies for intake process and case closure procedures on file at the subrecipient Fee schedule readily available An acknowledgement signed by the client that they have been advised/informed of fee schedule, intake

Standard	Measure
	process, and case closure process prior to receiving service
18.4 Caseloads & Waiting List Staff must have reasonable caseloads and cases must be accepted on priority basis. If the provider uses a wait list, they must have a policy in place that ensures that the wait list is appropriately managed and updated; and that they communicate the client's place on the wait list regularly.	Written policies and procedures for caseload management and case closures on file at the subrecipient

18.0 **Psychosocial Support**

HRSA Description:

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible people living with HIV to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- 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) or client incentives.
- HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.
- HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.
- Psychosocial Support staff are not required to be people living with HIV.

Source: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Goal: Psychosocial support services will decrease isolation for people living with HIV and support the wellbeing of people living with HIV.

Objective: Through one-on-one interactions and in small groups, psychosocial support promotes clients' engagement in health care and emotional support in a respectful setting. Subrecipients of psychosocial support assist in the development of coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, to help improve quality of life for participants.

Standard	**Measure**

19.1 Psychosocial Assessment The subrecipient must assess the psychosocial support needs of the client. The assessment can include the following topics: • Alcohol and drug use • Violence risk • Family • Social support • Occupational history • Education • Legal history • Financial • Development history • Spiritual • Cultural • Coping skills • Nutrition • Interests and abilities	Record of assessment evident in client file

Standard	**Measure**
• Mental health	
19.2 Psychosocial Support Counseling One-on-one and group counseling can include a wide range of topics, including, but not limited to: • Child abuse and neglect • Bereavement counseling • Pastoral *(must be available to clients from all faiths/religions)* • Domestic violence • Newly positive • Nutritional education *(must be performed by a non-registered dietician)* ***RWS does not require Psychosocial Support staff to be people living with HIV.***	Record of counseling and topics evident in the client file or group notes
19.3 Psychosocial Groups Group sessions are defined as three or more participants (not including the facilitator). Additionally, all support groups must have a topic and attendance must be documented. ***RWS does not require Psychosocial Support group facilitators to be people living with HIV.***	Records of group sessions must include of name of the facilitator, dates, topics, duration and attendance by client code and be available in subrecipient files.

HRSA GUIDELINES FOR HIV VERIFICATION

HRSA has developed client eligibility guidelines in response to the Office of Inspector General (OIG)'s findings that all Eligible Metropolitan Areas (EMAs) need to strengthen systems and controls to ensure that only individuals with HIV disease and their families receive services provided through Ryan White Part A funds. HRSA requires that each EMA should have in place written procedures to ensure client eligibility. HRSA further states that these procedures should be communicated to and be required of all service providers.

The HRSA Guidelines for HIV Verification, expected of all providers supported by Part A funds, include the following:

a. Primary documentation of positive HIV serostatus is kept in the client's file on-site in at least one location among the CARE Act funded network. Examples of acceptable proof of HIV serostatus include lab slips and physician statements.
b. Client files at every location should include primary documentation or reference to the primary documentation in the form of a certified referral form or a notation that eligibility has been confirmed (including the name of person/organization verifying eligibility, date, and nature and location of primary documentation).
c. Program monitoring activities of all service providers will include the review of documentation of client eligibility by programs/providers.

Following an OIG audit of the Boston EMA, the following citations were issued: the lack of HIV verification by the Subrecipients and the lack of client eligibility guidelines by the Recipient. Therefore, in response to HRSA's guidelines for client eligibility and OIG's citations for the lack of HIV verification, the Boston EMA has developed specific procedures for the verification of HIV status of all clients by all service providers supported by Part A funds. Refer to the following page for the Boston version of the HRSA policy.

BOSTON EMA GUIDELINES FOR HIV VERIFICATION

In response to the guidelines released by HRSA for establishing client eligibility and verification of HIV status, the Boston Public Health Commission has developed specific procedures for the verification of HIV status of all clients supported by BPHC funds. HRSA specifies that the primary documentation of positive HIV serostatus be kept in the client's file on-site in at least one location among the Ryan White funded network. In order to verify client eligibility and documentation of HIV status, an auditor (such as OIG) will need to visit the site that holds this documentation to review the client files. This type of review can only be done by obtaining and removing client identifiers to trace back the necessary documentation to each site. This procedure would jeopardize client confidentiality and privacy.

To maintain client confidentiality, the Boston EMA Guidelines for HIV Verification adds to the HRSA requirements by requiring that client eligibility for Ryan White Part A services for each **provider** must include HIV verification. **This documentation must be filed in client files at each program.**

The HRSA Guidelines for HIV Verification, expected of all providers supported by Part A funds, include the following:

a. Primary documentation of positive HIV serostatus: any document with medical provider's (MD, NP (ACRN), PA, RN, pharmacist) signature certifying HIV status. Examples include: letter from provider (on letterhead), copy of HIV-related prescriptions, lab results (lab slip), HDAP approval, HOPWA approval or home-delivered meals certification.
b. The Boston EMA Ryan White HIV/AIDS Program expects that all service providers will obtain primary documentation of HIV serostatus. This documentation must be included in all client files.
c. Program monitoring activities of all service providers will include the review of documentation of client eligibility

DEPARTMENT OF HEALTH & HUMAN SERVICES

February 25, 2013

Dear Colleague:

The purpose of this letter is to clarify questions and concerns raised by grantees and sub-grantees of the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) and Centers for Disease Control and Prevention (CDC) about HIV testing and linkage to care. Pursuant to the legislative intent of the RWHAP and the Administration's National HIV/AIDS Strategy (NHAS), it is imperative that individuals who are potentially eligible for RWHAP-funded services receive an accurate HIV diagnosis and are quickly linked to RWHAP-funded medical care.

In order to be eligible for RWHAP-funded medical care, patients must have a "diagnosis of HIV disease" (Sections 2604(c)(1), 2611, 2651(c)(1) and 2671(a) of the Public Health Service (PHS) Act). There is no legislative requirement for a "confirmed" HIV diagnosis prior to linkage to RWHAP-funded medical care, nor is there any specific statutory or program requirement related to the use of Western blot testing as the only means of confirmatory testing. Confirmatory testing may occur at the RWHAP-funded medical clinic. Tests to confirm the diagnosis of HIV disease could include the following[1]:

- Positive HIV immunoassay and positive HIV Western blot
- Positive HIV immunoassay and detectable HIV RNA
- Two positive HIV immunoassays (should be different assays based on different antigens or different principles)

Having positive results from only one HIV antibody test should not be a barrier to linkage to care to a RWHAP-funded clinic, or other HIV care providers, since the majority of people receiving a positive result from a single test have HIV infection and would benefit from quick linkage to ongoing care and prevention services. For example, an individual with one positive rapid test should be counseled about the likelihood of infection and the real (although small) possibility of a false positive result. He or she should be linked at that time, to an HIV care provider to receive follow-up HIV testing and, if confirmed, medical care.

Financial Eligibility Policy for Ryan White Services

Background

The Boston Public Health Commission (BPHC) HIV/AIDS Services Division (HASD) and Massachusetts Department of Public Health (MDPH) Office of HIV/AIDS (OHA) have developed a policy describing a local response to the U.S. Health Resources and Services Administration (HRSA) directive to implement financial eligibility criteria for Ryan White Part A and Part B services. HRSA's requirement is intended to ensure that Ryan White services are reserved for PLWHA with very limited financial resources.

Income Threshold

Effective March 1, 2013 (BPHC) and April 1, 2013 (MDPH), funded providers must screen people living with HIV clients for income eligibility, based on a threshold of 500% of the current Federal Poverty Level (FPL) as determined by the
U.S. Department of Health and Human Services (HHS), with an additional allowance for dependents based on the MassHealth dependent allowance (currently $3,960 per dependent). Individuals with incomes at or below this level will be eligible for HASD and OHA services. Subrecipients may continue to serve individuals with incomes above this level and must not deny services to clients based on income. However, Subrecipients may not use Ryan White funds to serve clients with incomes above the threshold. Subrecipients may implement a hardship waiver for clients with incomes over 500% of FPL whose out-of-pocket expenses have exceeded 10% of their income during the year. Subrecipients may continue to set lower financial eligibility levels for particular services in consultation with BPHC and MDPH.

HHS updates poverty guidelines annually, typically in late January. The best place to find updated, accurate information is on the HHS website at http://aspe.hhs.gov/poverty.

Screening and Documentation

Providers must screen for financial eligibility at intake and at six-month intervals thereafter and must document sources of income and FPL range in the client's record. Suitable documentation includes at least two recent paystubs with pay periods indicated, a copy of the most recent federal tax return, a W-2 for the most recent tax year, a 1099 form, and documentation of SSDI, SSI, unemployment compensation, and any other benefits or entitlements. If there are no earnings, the client record should contain a signed letter from the medical case manager or health care provider stating that the client has no income and indicating how the client is being supported.

Subrecipients may maintain their own processes to screen for and document financial eligibility. These processes should include documents that obtain accurate, updated income information while ensuring low-threshold access to care and services. To document eligibility for all services other than the HIV Drug Assistance Program (HDAP), Subrecipients may opt to create a 'self-attestation' form that documents a client's assertion that his or her income has not changed in the previous six months, since the last eligibility screening and documentation of income took place. This form must include the following: 1) a statement explaining that the client's income has not changed within the previous six months, following the last eligibility screening and income documentation process, 2) the client's printed name, 3) the subrecipient staff member's printed name, 4) the client's signature, and 5) the date the document is signed. The form is not accompanied by documentation of income. Self-attestation forms can be used only once during each twelve-month period. At annual re-certifications of client eligibility, Subrecipients must work with clients to obtain documentation of income and may not use the self-attestation form.

HASD and OHA staff will assess compliance with subrecipient policies during routine contract monitoring practices by reviewing documentation in client records.

Client Income Summary

Subrecipients may use or adapt the BPHC and MDPH Client Income Summary form to record a client's income and FPL. This form is intended to help facilitate access to other client services by communicating the results of financial eligibility screens that are completed by one service provider so that other providers do not need to duplicate this work. If the Client Income Summary form is not used, another means of documenting client income and FPL range must be created. With appropriate releases of information, Subrecipients working with common clients can coordinate ongoing six-month eligibility screens, share documentation of income and self-attestation forms, and assess eligibility without requesting the same information directly from the same client. Subrecipients sharing Client Income Summaries and self-attestation documents do not need to share actual backup income documentation; however, Subrecipients may request this documentation. Subrecipients should exchange contact information in order to facilitate communication and information-sharing.

Following is an example of how two Subrecipients might coordinate income eligibility screening processes and paperwork: A client's MCM (MCM) provider screens a client for financial eligibility and works with the client to complete the Client Income Summary. The MCM provider then refers the client for congregate meals. The client or MCM provider gives the completed Client Income Summary to the congregate meals provider along with a signed release of information form. The Subrecipients communicate about who will complete the financial eligibility screens every six months (in most cases, the MCM provider), exchange contact information, and decide how to share results and documentation on a routine basis.

As part of the site visit process, specifically the client file review, BPHC and MDPH may request the backup documentation used to determine financial eligibility. In situations where the referring subrecipient is also funded by Part A, and/or the client has signed the appropriate consent form for funder review, BPHC reserves the right to verify that appropriate eligibility review mechanisms are in place and that the related backup documentation is in the client file. If the referring subrecipient is not funded by Part A, BPHC may ask that a provider utilizing Client Income Summary forms without backup documentation requests such documentation from the provider/client who originally completed the financial eligibility review.

This policy became effective March 1st, 2013 and April 1st, 2013 for Parts A and B funded contracts respectively and applies to all HRSA-funded service areas. The policy was revised on June 21, 2013.

Single Sliding Fee Scale and Cap on Charges Policy for Ryan White Part A Services

Purpose of the Policy

To guide the administration of the Ryan White Part A Program to ensure compliance with grant requirements related to charges to clients as per the following Health Resources Service Administration guidance:

- Ryan White Legislation:
  - §2605 (e)(F)(A)
  - §2605 (e)(1)(B)
  - §2065 (e)(1-4)(C-F)
- Part A Assurances
- HRSA FOA
- BPHC Ryan White Part A Contract

Important Terms:

a. **Costs** are the accrued expenditures incurred by the recipient /subrecipient during a given period requiring the provision of funds for: (1) goods and other tangible property received; (2) services performed by employees, contractors, subrecipient, Subrecipients, and other payees.
b. **Charges** are the *imposition of fees* **upon payers** for the delivery of billable services.
c. **Payments** are the collection of fees from payers that are applied to cover some aspect of costs of billable services.
d. **Billable services** are those for which there is a payer source.
e. **Charge Master/Schedule of Charges** is a comprehensive listing of prices for billable services and/or procedures.
f. **Sliding fee** means that costs change according to the patient's income, lack of income, or ability to pay.

Policy and Procedures:

1. If the subrecipient charges health insurers for a service, the subrecipient must impose the same charge and provide a discount to uninsured clients using the service.

2. If an entity receiving Part A funds charges for services, it must do so on a sliding fee schedule that is available to the public and is based upon established fees that are reasonable and necessary. Establishing a fee schedule should not result in a bureaucratic system to means-test individuals or families before Part A supported services are available. The sliding fee scale is intended to protect clients from becoming so overwhelmed by financial burdens they leave the system. The sliding fee scale/schedule of charges shall not permit charges to clients with an income ≤ 100% FPL and permits nominal fees for clients with income >100% FPL.

A. The sliding Fee Scale to be implemented is:

Client FPL	Fee
<100%	No fee
101 – 200%	5% of fee
201 – 300%	10% of fee
301 – 400%	15% of fee
401 - 500%	25% of fee
>500%	100% of fee

B. The schedule of charges must be displayed in a conspicuous location(s) available to clients.

C. Subrecipient must have a written statement that no patient is denied care due to an inability to pay. Thus, clients can be charged but cannot be denied services if they have not been able to pay the charge.

3. Individual, annual aggregate charges to clients receiving Part A services must conform to statutory limitations. The term, "aggregate charges," applies to the annual charges imposed for all such services under Part A without regard to whether they are characterized as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges for services. This requirement applies to all service subrecipients from which an individual receives Part A funded services. The intent is to establish a ceiling on the amount of charges to recipients of services funded under Part A.

A. Annual limitation on the amounts of charges (i.e. caps on charges) for Ryan White services is based on the percent of the client's annual income, as follows:

Client FPL	Cap on Out-of-Pocket Expenses
<100%	N/A (No Out-of-Pocket Expenses)
101 – 200%	Actual gross income multiplied by 5%
201 - 300%	Actual gross income multiplied by 7%
>300%	Actual gross income multiplied by 10%

B. The cap on charges must be displayed in a conspicuous location(s) available to clients.

C. The client is responsible for keeping track of cumulative charges assessed across all the client's service subrecipients and should ensure that the information provided is accurate.

D. The client is responsible for keeping track of cumulative charges assessed across all the client's service subrecipients and should ensure that the information provided is accurate.

E. Subrecipient must have a written policy statement that no Ryan White Part A client is denied care due to an inability to pay. Subrecipient shall have billing, co-pay, and collection policies and procedures that do not:
   - Deny services for non- payment
   - Deny payment for inability to produce income documentation
   - Require full payment prior to service

- Include any other procedure that denies services for non-payment

4. The subrecipient will establish and maintain a schedule of charges and a policy that includes a cap on charges with the following:
   A. Responsibility for client eligibility determination to establish individual fees and caps.
   B. Tracking of Part A charges or medical expenses inclusive of enrollment fees, deductibles, co-payments, etc.
   C. A process for alerting the billing system when the client has reached the cap and should not be further charged for the remainder of the year.

5. The subrecipient must ensure that personnel are aware of, and consistently follow, the policy for schedule of charges and the cap on charges.

Monitoring

1. The BPHC Ryan White Services Division (RWS) shall review subrecipient policies for the following to ensure they meet legislative requirements:
   A. The schedule of charges and sliding fee scale to ensure they meet legislative requirements.
   B. The cap on charges.

2. The RSWD shall review client records and documentation of actual charges and payments to ensure the policy is being correctly and consistently enforced and clients below 100% of FPL are not being charged for services.

3. The RSWD will review the accounting system and records of charges and payments to ensure compliance with sliding fee scale requirements and cap on charges requirements and review client records for eligibility determination to ensure consistency with policies and federal requirements.

4. Verify that the schedule of charges, the sliding fee scale, and the cap on charges is displayed in visible location(s) available to clients.

5. The RWS shall review:
   a. The accounting system for tracking patient charges and payments.
   b. The process for alerting the billing system when the client has reached the cap and should not be further charged for the remainder of the year.
   c. The charges and payments to ensure that charges are discontinued once the client has reached his/her annual cap.
   d. Documentation reflecting annual acknowledgement of enrollment staff and fiscal staff of training on policies related to schedule of charges and cap on charges.

6. The RSWD shall review the policy indicating that Ryan White clients will not be denied services based on inability to pay and documentation reflecting annual acknowledgement of enrollment staff and fiscal staff of this policy.

Annual Recertification Summary Form

The purpose of this form is to document eligibility for the Ryan White HIV/AIDS Program services. The form can be shared among service providers to verify Ryan White Part A Client's eligibility. *This form is valid for one year (12 months).*

NOTE: The format of this document is optional and is just one way an agency may choose to document client eligibility. This template can be used to upload into e2Boston as the Annual Recertification form.

Agency Name:	
Agency Staff:	
Client Name:	
Client Code:	**Client UCI:**
Signature/Effective Date:	**Expiration Date (12 months after):**

Annual Recertification:

Annual Recertification must be collected one time every 12 months to update/upload a client's eligibility for Ryan White Part A services. This includes:

- Income Verification
- Residency Verification
- Insurance Status

INCOME VERIFICATION DOCUMENT

Please select one (1) of the income verification documents:

- ☐ Paystub(s)
- ☐ Safety net correspondence (IESSA, SNAP, etc.)
- ☐ Attestation/Affidavit signed by the Client (For instances of homelessness and/or other extenuating circumstances)
- ☐ HDAP Approval Letter
- ☐ PMI (Patient Medical Information)
- ☐ Bank Statement (s)
- ☐ Unemployment income
- ☐ Attestation/Affidavit (to states no income)
- ☐ Tax Return

RESIDENCY VERIFICATION DOCUMENT

Please select one (1) of the residency verification documents:

- ☐ Utility Bill
- ☐ Official Correspondence from Government Agency
- ☐ Paystub(s)
- ☐ Insurance verification document
- ☐ PMI (Patient Medical Information)

- ☐ Attestation/Affidavit signed by the Client (For instances of homelessness and/or other extenuating circumstances)
- ☐ License (not expired)
- ☐ Rental agreement
- ☐ Voter Registration
- ☐ Tax return
- ☐ SSI/SSDI Statement

INSURANCE VERIFICATION DOCUMENT

Please select one (1) of the insurance verification documents:

- ☐ EOB/EOP from insurance
- ☐ Letter verifying status from insurance
- ☐ Premium payment bill
- ☐ Virtual Gateway/Any 3rd party portal printout
- ☐ Health Insurance card (Medicare/Medicaid/ etc.)
- ☐ HDAP Approval letter

Client Signature:_____

Date:_____

CLIENT CONFIDENTIALITY PROCEDURES

Boston Public Health Commission believes strongly in protecting client confidentiality. The following guidelines must be adhered to by all providers:

1. Client identifying information should never be transmitted to BPHC by mail or email.

2. All clients must be offered the opportunity to sign a *Client Acknowledgement Form* that BPHC staff may, in accordance with Federal guidelines, perform a visual review of their client file. Except in the case of suspected fraud or criminal wrongdoing, ***no client identifying information shall be removed from the agency's premises.***

3. The *Client Acknowledgement Form* must inform the client that in accordance with BPHC's HIPAA Business Associate Agreement with funded Subrecipients, ***BPHC reserves the right to review client files even in the absence of signed consent, if necessary.***

4. All client consent forms must have an expiration date of **one year** from the date of signature.

Providers failing to implement the above procedures may have their contracts suspended and/or revoked.

SAMPLE CLIENT ACKNOWLEDGEMENT FORM

Agency Letterhead

Consent/Acknowledgement of Funder Review of File

I, _____, acknowledge that the staff of _____has informed me of the authority of the Boston Public Health Commission (BPHC) to examine and review my client record. The purposes of review are for monitoring only. The review may include information such as name, HIV status and related diagnosis, substance abuse treatment, medical care and treatment, financial circumstances, living arrangements, and other information as requested. I understand that the review will be visual only, no records will be copied, and no information identifying me will be recorded.

In no way does this acknowledgement authorize BPHC to remove information or collect personal identifiers, except in cases of suspected fraud or other criminal wrongdoing.

This signed acknowledgement will have duration of **one year** from the date of signing below. I understand I am not required by law to consent to release this information but choose to do so willingly and voluntarily. I understand I may revoke consent at any time except to the extent action has been taken in reliance of my consent.

I am aware that BPHC has a business agreement with the above-mentioned agency and is a covered entity under the HIPAA Privacy Rule. Hence, BPHC is permitted to review my file without a signed consent/acknowledgement form.

_____Client's Signature

_____Date:

_____Birth date:

_____Witness:

_____Date:

MAINTENANCE OF CLIENT FILE POLICY

Programs must maintain a file on site for each client receiving Part A services which includes, at minimum, the following information unless otherwise noted.

- ☐ Updated Release of Information/Consent for Funder Review
- ☐ Initial Intake Information
  - HIV Diagnosis Verification
  - Initial Needs Assessment
- ☐ Annual Eligibility Documentation
  - Insurance Verification
  - Income Verification
  - Residency Verification
  - Assessment/Reassessment (as applicable)
- ☐ Annual Signatures on Client's Rights and Responsibilities, Grievance, and Confidentiality Policies
- ☐ Service Specific measures as denoted in the Service Standards

PAYER OF LAST RESORT POLICY

Ryan White HIV/AIDS Program funds are the payer of last resort in relation to all other state and federal funding sources. This includes Medicaid.

Specifically, federal policy requires the following:

- Ryan White HIV/AIDS Program funds may not be used to pay for Medicaid covered services for Medicaid beneficiaries.

- Ryan White HIV/AIDS Program providers who provide Medicaid covered services must be Medicaid-certified.
- Ryan White HIV/AIDS Program providers are expected to vigorously pursue Medicaid enrollment for individuals who are eligible for Medicaid coverage.
- Ryan White HIV/AIDS Program providers must seek payment from Medicaid when they provide a Medicaid covered service for a Medicaid beneficiary.
- Ryan White HIV/AIDS Program providers must back bill Medicaid for any Ryan White Act funded services provided to Medicaid-eligible clients once Medicaid eligibility is determined.

Providers are expected to exhaust mandatory Medicaid dollars before utilizing discretionary Ryan White HIV/AIDS Program funds. The Payer of Last Resort policy is currently part of all BPHC Part A provider contracts and is also restated on all program budgets. If you have questions regarding these policies, please feel free to call our office.

VERIFICATION OF DSM-5 DIAGNOSIS FOR PART A FUNDED MENTAL HEALTH PROGRAMS

The federal definition of Part A Mental Health services is:

Psychological and psychiatric treatment and counseling services to individuals experiencing a disorder diagnosable under the Diagnostic and Statistical Manual 5 (DSM-5).

This diagnosis must be documented in client files and Mental Health services must be provided by a mental health professional that is either licensed or authorized within the State.

END OF 2024 RFP

BACK COVER