

December 10, 2009

TO: OFFICE OF AIDS HIV CARE BRANCH CONTRACTORS AND CALIFORNIA CONFERENCE OF LOCAL AIDS DIRECTORS

FROM: CLARISSA POOLE-SIMS, ACTING CHIEF, HIV CARE BRANCH, OFFICE OF AIDS

SUBJECT: HIV CARE PROGRAM and MINORITY AIDS INITIATIVE (MAI) 2009/10 GUIDANCE

Effective Date: July 1, 2009 thru June 30, 2010

The purpose of this guidance is to provide you with information about the changes that have occurred in the California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) with respect to HIV Care Programs for the fiscal year (FY) 2009-10 contract period which began July 1, 2009. We anticipate following up with additional information as new issues arise and/or further direction is needed.

The 2009 State Budget Act eliminated the General Fund appropriations for the State Office of AIDS' (OA) HIV/AIDS care and housing programs. OA has redirected its federal care funds to maximize support for the most critical HIV/AIDS services. Care services are being funded using a Single Allocation Model (SAM) to consolidate program funds into a single contract in each local health jurisdiction or service area. In order to facilitate these reductions, OA has taken the following steps:

- Eliminated the following *stand-alone* programs: Early Intervention Program (EIP) and the associated Positive Changes, Bridge Project, and Pathways; Therapeutic Monitoring Program (TMP); Case Management Program (CMP); Care Services Program (CSP); and the Residential AIDS Licensed Facilities Program (RALF).
- Continued to administer Health Resources and Services Administration (HRSA) Ryan White Part B funds to support the newly created HIV Care Program (HCP) which is similar to the former CSP. The HCP utilizes HRSA service categories (below) and supports the same types of services that the *stand-alone* programs once provided. HRSA Part B funds are allocated to local health jurisdictions or other service areas via the SAM.
- Continued to administer the HRSA Minority AIDS Initiative (MAI) funds which support outreach and treatment education to increase the use of ADAP in communities of color. MAI funds are allocated to local health jurisdictions via the SAM.

- Continued to administer the Housing Opportunities for Persons with AIDS (HOPWA) Program as a stand alone program. This is not included in the SAM at this time. For information about the OA HOPWA Program, go to: <http://www.cdph.ca.gov/PROGRAMS/AIDS/Pages/OAHOPWA.aspx>
- Continued to administer the AIDS Medi-Cal Waiver Program. This is not included in the SAM. For information about the AIDS Medi-Cal Waiver Program, go to: <http://www.cdph.ca.gov/programs/aids/Pages/OACBC.aspx>

### **Single Allocation Model (SAM)**

The SAM is an administratively streamlined model for providing OA's care and support funding throughout the state. Based on local needs, OA allocates available care funding via a single contract, the SAM, with either the local health jurisdiction or with a community-based organization (CBO).

The SAM includes HRSA Part B funds and, as available, Part B supplemental funds to support the HCP. In some local health jurisdictions, the SAM also includes an additional, separate allocation of MAI funds. For those jurisdictions receiving additional MAI funds, separate guidance for MAI funding is contained in this document.

#### **1. HIV Care Program (HCP)**

The goal of the HCP is to serve uninsured- and underinsured clients with HIV disease who do not have access to care-related services. The HCP fills gaps in care not covered by other resources. HCP is a flexible, two-tiered approach to service prioritization, provision and delivery and is based upon the HRSA-defined service categories.

**Tier One:** HCP prioritizes the HRSA category *Outpatient/Ambulatory Medical Care* as the Tier One service.

**Tier Two:** Tier Two services support access to Tier One care, maintenance in Tier One care, and reduce the risk of treatment failure and/or HIV transmission.

If all Tier One needs are met, local contractors will determine which Tier Two service categories will be funded, based on local need and available resources. Note that OA may consider, in consultation with local stakeholders, further prioritization of services that are currently ranked as Tier 2 for the next contract period.

## TIER ONE AND TIER TWO SERVICE CATEGORY DEFINITIONS

Tier One Services	
<p><b>Outpatient/Ambulatory Medical Care</b></p>	<p><u>Service providers</u>: Includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician’s assistant, clinical nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe Antiretroviral (ARV) therapy in an outpatient setting.</p> <p><u>Services</u> include diagnostic testing, early intervention and risk assessment, preventive health care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty medical care (includes all medical subspecialties).</p> <p><i>Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service’s (PHS) guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.</i></p> <p><u>Settings</u> include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings.</p>

<b>Tier Two Services</b>	
<b>Case Management Services (non-medical)</b>	<p>Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services.</p> <p>Non-medical case management does <u>not</u> involve coordination and follow-up of medical treatments.</p>
<b>Child Care Services</b>	<p>Are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or RWHAP-related meetings, groups, or training.</p> <p>This does not include child care while the client is at work.</p>
<b>Early Intervention Services (EIS)</b>	<p>Includes counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.</p>
<b>Emergency Financial Assistance</b>	<p>Provision of short-term payments to agencies or the establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication, when other resources are not available.</p> <p>NOTE: Part A and Part B programs must allocate, track, and report these funds under specific service categories as described under 2.6 in Division of Service Systems (DSS) Program Policy Guidance No. 2 (formally Policy No. 97-02).</p>
<b>Food Bank / Home-Delivered Meals</b>	<p>Provision of actual food or meals.</p> <p>It does <u>not</u> include finances to purchase food or meals but may include vouchers to purchase food. The provision of essential household supplies such as hygiene items and household cleaning supplies should</p>

<b>Tier Two Services</b>	
	be included in this item.
<b>Health Education / Risk Reduction</b>	Provision of services that educate <i>clients living with HIV</i> about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.
<b>Health Insurance Premium and Cost Sharing Assistance</b>	Provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, copayments, and deductibles.
<b>Home and Community-Based Health Services</b>	<p>Includes skilled health services furnished to the individual in the individual's home, based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services.</p> <p>Inpatient hospital services, nursing home and other long-term care facilities are <u>not</u> included as home and community-based health services.</p>
<b>Home Health Care</b>	Is the provision of services in the home by licensed health care workers such as nurses, and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.
<b>Hospice Services</b>	Are end-of-life care provided to clients in the terminal stage of an illness. It includes room, board, nursing care, counseling, physician services, and palliative

<b>Tier Two Services</b>	
	therapeutics. Services may be provided in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services.
<b>Housing Services</b>	<p>Provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them.</p> <p>Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.</p> <p><b><i>Housing services are limited to 24 cumulative months. All services rendered after March 27, 2008 will be counted towards the cumulative 24 months.</i></b></p>
<b>Legal Services</b>	<p>Are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders, and 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 Ryan White HIV/AIDS Program.</p> <p>Legal services do <u>not</u> include any legal services to arrange for guardianship or adoption of children after the death of their normal caregiver.</p>
<b>Linguistic Services</b>	Includes the provision of interpretation and translation services, both oral and written.
<b>Local AIDS Pharmaceutical Assistance (APA, not ADAP)</b>	Are local pharmacy assistance programs implemented by a Part A, B, or C grantee or a Part B grantee consortium to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g., primary care or case management) to

<b>Tier Two Services</b>	
	<p>the clients that they serve through a Ryan White HIV/AIDS Program contract with their grantee. Programs are considered APAs if they provide HIV/AIDS medications to clients and meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>• Have a client enrollment process;</li> <li>• Have uniform benefits for all enrolled clients;</li> <li>• Have a record system for distributed medications; and</li> <li>• Have a drug distribution system.</li> </ul> <p>Local APAs are similar to AIDS Drug Assistance Programs (ADAPs) in that they provide medications for the treatment of HIV disease. However, local APAs are not paid for with Part B funds “earmarked” for ADAP.</p> <p>Programs are <u>not</u> APAs if they dispense medication in one of the following situations:</p> <ul style="list-style-type: none"> <li>• As a result or component of a primary medical visit;</li> <li>• On an emergency basis (defined as a single occurrence of short duration); or</li> <li>• By giving vouchers to a client to procure medications.</li> </ul>
<b>Medical Transportation Services</b>	<p>Conveyance services provided, directly or through voucher, to a client so that he or she may access health care services. Medical transportation is classified as a support service and is used to provide transportation for eligible Ryan White HIV/AIDS Program clients to core medical services and support services.</p> <p>Medical transportation must be reported as a support service in all cases, regardless of whether the client is transported to a medical core service or to a support service.</p>
<b>Medical Case Management Services (including treatment adherence)</b>	<p>Are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing</p>

<b>Tier Two Services</b>	
	<p>assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include:</p> <ul style="list-style-type: none"> <li>▪ initial assessment of service needs;</li> <li>▪ development of a comprehensive, individualized service plan;</li> <li>▪ coordination of services required to implement the plan;</li> <li>▪ client monitoring to assess the efficacy of the plan; and</li> <li>▪ periodic re-evaluation and adaptation of the plan as necessary over the life of the client.</li> </ul> <p>It includes client-specific advocacy and review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.</p>
<b>Medical Nutrition Therapy</b>	<p>Is provided by a licensed registered dietician outside of a primary care visit. The provision of food, nutritional services and nutritional supplements may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician.</p> <p>Nutritional services not provided by a licensed, registered dietician shall be considered a support service. Food, nutritional services and supplements not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician also shall be considered a support service.</p>
<b>Mental Health Services</b>	<p>Are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social</p>

<b>Tier Two Services</b>	
	workers.
<b>Oral Health Care</b>	Includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
<b>Outreach Services</b>	<p>Programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status (i.e., case finding) so that they may become aware of, and may be enrolled in care and treatment services.</p> <p>These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.</p> <p>Outreach services do <u>not</u> include HIV counseling and testing or HIV prevention education.</p>
<b>Psychosocial Support Services</b>	Are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.
<b>Referral for Health Care / Supportive Services</b>	Directing a client to a service in person or through telephone, written, or other type of communication. Referrals for health care/supportive services that were not part of ambulatory/outpatient medical care services or case management services (medical and non-medical) should be reported under this item. Referrals

<b>Tier Two Services</b>	
	for health care/supportive services provided by outpatient/ambulatory medical care providers should be included under outpatient/ambulatory medical care service category. Referrals for health care/supportive services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category, Medical Case Management or Case Management (non-medical).
<b>Rehabilitation Services</b>	Are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.
<b>Respite Care</b>	Provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.
<b>Substance Abuse Services (outpatient)</b>	Provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
<b>Substance Abuse Services (residential)</b>	Provision of treatment to address substance abuse problems (including alcohol and/or legal or illegal drugs) in a residential health service setting (short-term).
<b>Treatment Adherence Counseling</b>	Provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatment by non-medical personnel outside of the medical case management and clinical setting.

## **Eligibility**

Individuals with HIV/AIDS are eligible for HCP services with proof of HIV/AIDS diagnosis. Families of clients with HIV/AIDS may also be eligible for selected services. The proof of HIV diagnosis must contain the client's name, i.e., a physician diagnosis or positive test result with the client's name on the diagnosis or test result. Anonymous testing results are not acceptable.

The current Ryan White Treatment Modernization Act (RWTMA), which is the governance for HRSA Part B, states that "funds received ... will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by sources other than Ryan White funds. Therefore, contractors must ensure that HRSA Part B/HCP funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service under any State compensation program, under an insurance policy, or under any Federal or State health benefits program, by an entity that provides health services on a prepaid basis, or any other funding source.

It is the responsibility of the contractor and any subcontractors to ensure that eligibility for other funding sources (e.g., Medi-Cal or Medicare, other local or state-funded HIV/AIDS programs, or private sector funding, etc.) is aggressively and consistently pursued and to make effective use of strategies to coordinate between RWTMA Part B and third-party payers that are ultimately responsible for paying the cost of services provided to eligible/covered clients. *Note that the OA will be increasing attention to monitoring and compliance with this requirement. OA will utilize ARIES in addition to program monitoring for this purpose. Further detail will be provided.*

## **Budget Documents**

Local health jurisdictions and CBOs that have been allocated HCP funds have already received the Budget Guidance for 2009/10 issued on October 10-11, 2009. Budget documents may be updated annually and will be available in the future on the OA website.

## **Reporting**

HCP contractors are required to submit quarterly financial and narrative reports. The quarterly HCP Financial Report tracks expenditures to date for the contractor and any subcontractors and includes the total number of unduplicated clients served. The HCP Narrative Report is an opportunity for contractors to describe general accomplishments, issues or concerns, and any technical assistance and/or training needs of the contractor and/or subcontractors.

Contractors may access the HCP Financial Report (<http://www.cdph.ca.gov/programs/aids/Documents/FormCareHCPFinancialReport.xls>); and the HCP Narrative Report (<http://www.cdph.ca.gov/programs/aids/Documents/FormCareHCPNarrativeReport.doc>)

The quarterly reports are due as follows:

Reporting Period	Due Date
July 1 – September 30, 2009	February 16, 2010
October 1 – December 31, 2009	February 16, 2010
January 1 – March 31, 2010	May 14, 2010
April 1 – June 30, 2010	August 16, 2010

### Data Collection and Reporting

Contractors must ensure that they, and any subcontractors, collect the HCP minimum dataset. The HCP minimum dataset includes data elements required by (a) HRSA to complete the Ryan White Program Data Report (RDR), the Ryan White Program Service Report (RSR), selected HRSA HIV/AIDS Bureau (HAB) quality management (QM) indicators, and the Women, Infants, Children, and Youth (WICY) Report, and (b) CDPH/OA for its development of estimates and reports (i.e., estimate of unmet need for HIV medical care, statewide epidemiologic profile, Statewide Coordinated Statement of Need) and to monitor and evaluate program activities.

Contractors and/or subcontractors must directly enter data into the AIDS Regional Information and Evaluation System (ARIES) within two weeks from a client's date of service. Contractors and/or subcontractors may import data into ARIES from other data collection systems after obtaining written approval from CDPH/OA. Contractors and/or subcontractors may not use CDPH/OA funds to develop or maintain their import systems.

Contractors and/or subcontractors must electronically submit the aggregate-level Ryan White Program Data Report (RDR) through HAB's Electronic Handbook (EHB). The RDR reporting period is January 1 through December 31 of the previous calendar year. Submission deadlines will be announced in ARIES Policy Notices.

Contractors and/or subcontractors must electronically submit a Provider Report for the RSR through HAB's EHB. Unless exempted by HRSA, contractors and/or subcontractors who provide RSR-eligible services must also upload a Client Report, which contains client-level data, as an XML data file to HAB's EHB.

The RSR is due twice a year: (a) The first report includes data from the first six months of the current calendar year, and (b) The second report includes all the data from the entire previous calendar year. Submission deadlines will be announced in ARIES Policy Notices.

Contractors shall ensure compliance with the policies and procedures outlined in ARIES Policy Notices issued by the CDPH/OA. Policy Notices are available at <http://www.projectaries.org/>

## **Invoicing**

Contractors may submit invoices and invoice expenditure detail forms either monthly or quarterly. Contractors must notify their Care Operations Advisors whether invoices will be submitted for monthly or quarterly billing periods. After the execution of the contract, invoices are due 45 days following the end of the selected billing period.

Contractors will be required to submit an HCP Invoice Expenditure Detail with each HCP Invoice (<http://www.cdph.ca.gov/programs/aids/Documents/FormCareHCPInvoiceFormp.xls>). The HCP Invoice Expenditure Detail provides data required by HRSA for OA reporting.

## **Line Item Shifts**

Subject to prior review and approval of OA, line item shifts of up to 15% of the annual contract total are allowed, so long as the annual agreement total neither increases nor decreases. Contractor must submit an In-House Revision form, for approval, for line item shifts to OA. Please contact your Care Operations Advisor for a copy of the In-House Revision form.

## **Budget Revisions**

Revisions of dollar amounts or service categories among subcontractors are referred to as budget revisions. Because these dollar amounts are reported in the "Other Costs" line item, they are not considered line-item changes. Subcontractors must notify the Contractor of any budget shifts or changes in services or allocations. The Contractor must notify their Care Operations Advisor, via e-mail, before the changes go into effect. The e-mail must include where funds/services are reduced and where the funds/services are increased.

## **A-133 Audit Requirements**

The Federal Office of Management and Budget's (OMB) Circular, No. A-133, Audits of States, Local Governments, and Non-Profit Organizations, sets forth standards for obtaining consistency and uniformity among federal agencies for the audit of states, local governments, and non-profit organizations expending federal awards. OMB Circular No. A-133 states that non-federal entities (state, local government or non-profit organization) that expend \$500,000 or more in a year in federal awards shall have a single or program-specific audit conducted for that year. Exhibit D(F) in the agreement between the Contractor and OA, requires that the audit be completed by the end of the ninth month following the end of the audit period. The HRSA has enacted a requirement for LHJ's to submit copies of their audit reports to the OA for recordkeeping and dissemination to the HRSA. HRSA is developing guidance on this requirement. OA will provide additional guidance on this requirement once it is received from HRSA

## **Contacts and Technical Assistance**

HCP Care Operations Advisors are available to provide technical assistance and ongoing contract compliance and monitoring functions. Program Evaluation and Research Section staff is available to provide ongoing technical assistance related to data reporting and collection. Contact persons can be found here: <http://www.cdph.ca.gov/programs/aids/Documents/FormCareHCPAdvisorsResContactList.doc>.

## **2. Minority AIDS Initiative (MAI)**

The goal of HRSA MAI funding is to increase access to, and engagement in, HIV/AIDS medical care for HIV-positive persons of color, including access to AIDS Drug Assistance Program (ADAP) or comparable HIV/AIDS treatment resources, e.g., Medi-Cal. This goal is achieved through the provision of outreach and treatment education services for HIV-infected persons of color who have never been in care, despite an awareness of their serostatus, or who have been lost to care. MAI activities are similar to those previously provided with MAI funding, *but must now be focused on persons of color only* (please note that in the past, additional funding sources were also used in the Bridge Project creating more flexibility in providing services to non-MAI populations). Data reporting requirements are also similar.

The following seventeen (17) local health jurisdictions are funded for MAI activities in FY 2009-10:

Alameda	Kern	Monterey
Sacramento	San Francisco	Santa Clara
Contra Costa	Long Beach	Orange
San Bernardino	San Joaquin	Ventura
Fresno	Los Angeles	Riverside
San Diego	San Mateo	

### **Service Provision**

Local health jurisdictions receiving MAI funding for outreach and treatment education services may employ MAI outreach staff or support activities to identify HIV-infected persons who are out-of-care or lost-to-care and gradually engage them in appropriate HIV care and treatment services. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; and be targeted to persons of color populations known through local epidemiologic data to be at disproportionate risk for HIV infection.

Outreach staff funded with MAI resources is strongly encouraged to be culturally and linguistically competent “street-level” workers who reflect the communities they serve. Highly recommended is experience in two or three of the following areas: street-based outreach, HIV counseling and testing, prevention case management, psychotherapy or counseling, health education, or HIV case management. Outreach staff funded with MAI resources will take actions to reduce or eliminate any cultural or other barriers that prevent access to and/or continued engagement in care and treatment services.

The contractor and/or MAI outreach staff should collaborate with community resources and entities that serve as key points of entry into medical care, including but not limited to, emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease (STD) clinics, HIV counseling and testing sites, mental health programs, homeless shelters, Federal Qualified Health Centers, jail and prison Transitional Case Management Programs, etc. to coordinate and integrate HIV care service delivery.

### **Eligibility**

HIV-infected persons of color who have never been in care or who have been lost-to-care are eligible for MAI services. For those who have never been in care, verification of serostatus should occur after entry into care. Contractors must ensure that MAI funds are payer of last resort by ensuring that service

providers bill all other third-party payers, including Medi-Cal, before invoicing MAI.

### **Budget Documents**

Local health jurisdictions that have been allocated MAI funds received their Budget Guidance for 2009-10 on November 10, 2009. Budget documents may be updated annually and will be available in the future on the OA website.

### **Monthly Tracking and Quarterly Reporting**

Until MAI reporting is incorporated into the state's ARIES data reporting system, local health jurisdictions receiving MAI funds for outreach and treatment education services must track and report activities manually. Data collection forms are to be submitted on a monthly basis. OA revised two forms which were used previously for similar outreach activities. Both the MAI Client Contact Reporting Form (<http://www.cdph.ca.gov/programs/aids/Documents/FormCareMAIClientContactReportingForm.pdf>) and the MAI Demographic Reporting Form (<http://www.cdph.ca.gov/programs/aids/Documents/FormCareMAIDemographicReportingForm.pdf>) are to be completed and faxed to OA at (916) 449-5959, on a monthly basis.

Local health jurisdictions receiving MAI funding must also provide a Quarterly Narrative Status Report that includes program accomplishments, successful outreach strategies, challenges and lessons learned, problems or issues, and requests for training and technical assistance.

Sites may access the MAI Quarterly Narrative Status Report Form (<http://www.cdph.ca.gov/programs/aids/Documents/FormCareMAIQtrlyNarrativeStatusRpt.doc>) through the OA website.

The quarterly narrative reports are due as follows:

<b>Reporting Period</b>	<b>Due Date</b>
July 1 – September 30, 2009	February 16, 2010
October 1 – December 31, 2009	February 16, 2010
January 1 – March 31, 2010	May 14, 2010
April 1 – June 30, 2010	August 16, 2010

### **Invoicing**

Contractors may submit invoices and invoice expenditure detail forms on either a monthly or quarterly basis. Contractors must notify the OA MAI contact person whether invoices will be submitted for monthly or quarterly billing periods. After

the execution of the contract, invoices are due 45 days following the end of the selected billing period.

Contractors will be required to submit the MAI Invoice Expenditure Detail (<http://www.cdph.ca.gov/programs/aids/Documents/FormCareMAIInvoiceExpendDetailp.xls>) with the MAI Invoice (<http://www.cdph.ca.gov/programs/aids/Documents/FormCareMAIInvoiceFormp.xls>). The MAI Invoice Expenditure Detail provides data required by HRSA for OA reporting.

### **Contacts and Technical Assistance**

For further information specific to MAI outreach and treatment education services, you may contact:

Toni Post at (916) 449-5970 or [toni.post@cdph.ca.gov](mailto:toni.post@cdph.ca.gov);  
Carol Crump at (916) 449-5965 or [carol.crump@cdph.ca.gov](mailto:carol.crump@cdph.ca.gov), or  
Carol Russell at (916) 449-5962 or [carol.russell@cdph.ca.gov](mailto:carol.russell@cdph.ca.gov).