



HIV CARE PROGRAM

MINORITY AIDS INITIATIVE

BUDGET AND OPERATIONS GUIDANCE

May 2012

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HIV CARE PROGRAM BUDGET AND OPERATIONS GUIDANCE

I. Introduction

As the State grantee for Ryan White (RW) Part B, the California Department of Public Health, Center for Infectious Diseases, Office of AIDS (OA) allocates those funds for the administration of the HIV Care Program (HCP) and Minority AIDS Initiative (MAI) through contracts with local health jurisdictions (LHJs) and community-based organizations (CBOs) for the provision of medical and support services to persons living with HIV/AIDS.

For Health Resources and Services Administration (HRSA) policy requirements and legislative updates, refer to [HRSA's website](#) or go to <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>.

II. Purpose

This Guidance is designed to provide Contractors and Service Providers with the technical assistance needed to ensure efficient administration of invoices, reports, budgets, and contract monitoring for HCP and MAI.

When read online, this document provides hyperlinks to additional resource available on the World Wide Web.

III. Technical Assistance Contacts

Contract Monitoring, Progress Reporting, General Technical Assistance: Access OA Care Operations Advisor Contact Information by clicking [here](#) or go to <http://www.cdph.ca.gov/programs/aids/Documents/11MAD3cCareAdvisors.pdf>.

Invoicing and Financial Reporting, Ivo Klemes, ivo.klemes@cdph.ca.gov.

Section 1. Budgets

OA uses the HRSA approved State Direct Services Category to allocate Part B funds to local health departments and CBOs. This allows the Contractor the maximum flexibility when prioritizing Part B funds.

Program budgets for Year 3 (fiscal year [FY] 2012-13) services must be submitted as instructed in this guidance. Contractors are required to maintain accurate, detailed records of services and expenditures associated with RW Part B funds.

Budgets should be based on program planning per instruction included in the HCP and MAI Guidance. It may be necessary to estimate the number of clients who are eligible for other programs in order to more accurately estimate budgeted funds for each service category.

Contractors are advised to work with their assigned OA Care Operations Advisor if they have questions regarding this guidance.

Budgets must be e-mailed to MAMOUdocs@cdph.ca.gov.

Note:

- MAI allocations, if applicable, are **not** to be combined in the HCP budget and are to be submitted using separate MAI budget forms.
- Contractors and Service Providers must consider budgeting for service categories that represent unmet need in their LHJ.

Allocations

The Single Allocation Model is an administratively streamlined model for providing care and support funds to local providers. Based on the specific needs, appropriateness, and capacity at the county level, OA contracts with either the county health department or a CBO, as the single Contractor in a given LHJ.

Please visit OA's website at:

<http://www.cdph.ca.gov/programs/aids/Documents/12MADAllocByContractor.pdf> for more information regarding contract numbers and allocations.

[Click Here](#) for detailed information about the HCP and MAI allocation processes or on OA's website at:

<http://www.cdph.ca.gov/programs/aids/Pages/OALocalAllocationsFY1213.aspx>.

HCP Allowable Services

The HIV care services to be provided under HCP are consistent with HRSA-defined service categories.

For a list of HRSA service categories, refer to the HRSA Part B manual online at: <http://www.hab.hrsa.gov/Resources/partbmanual/servicecategory.html>.

You can also refer to the HCP/MAI Program Guidance on OA's website at: <http://www.cdph.ca.gov/programs/aids/Pages/tOACareProviders.aspx> as well as Appendix A and B located at the end of this document.

Tier I
(Core Medical
Services)

HCP prioritizes the HRSA category **Outpatient/Ambulatory Medical Care** as a Tier I service. There are additional HRSA Core Medical Services allowable in Tier I which include, but are not limited to, primary medical care, laboratory testing, medical history taking, health screening, prescribing and managing medications.

Note: A written explanation is required for all Contractors **not** providing Outpatient/Ambulatory Care with HCP funds. The explanation **MUST** include where the clients in your service area are receiving their Outpatient/Ambulatory Care.

Tier II
(Support Services)

Tier II services support access to Tier I care, maintenance in Tier I care, and reduce the risk of treatment failure and/or HIV transmission. To provide the greatest flexibility to local providers, the list of HRSA service categories included in Tier II of HCP is extensive and varied.

- Case Management (non-medical)
- Child Care Services
- Emergency Financial Assistance
- Food Bank/Home-Delivered Meals
- Health Education/Risk Reduction
- Housing Services
- Legal Services
- Linguistic Services
- Medical Transportation Services
- Outreach Services
- Psychosocial Support Services
- Referral - Health Care/Supportive Services
- Rehabilitation Services
- Respite Care
- Substance Abuse Services-(residential)
- Treatment Adherence Counseling

MAI Allowable Services (If Applicable)

The goal of MAI 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), Medi-Cal, or other appropriate programs providing HIV medications. This goal is achieved by providing outreach and treatment education to HIV-infected persons of color.

MAI services are specifically for HIV-infected persons of color who have never been in care despite an awareness of their HIV-positive status or **who have been lost to care**. In accordance with HRSA policy, there are only two allowable service categories for Part B MAI: 1) Outreach; and 2) Treatment Education. See HCP/MAI Program Guidance for explanation of the definition of the service categories on OA's website, under 'Resources for Care Providers' at:

<http://www.cdph.ca.gov/programs/aids/Pages/tOACareProviders.aspx>.

Early Identification of Individuals with HIV/AIDS

The Early Identification of Individuals with HIV/AIDS (EIIHA) initiative is a new requirement of the federal RW Program. EIIHA aims to identify, inform, and refer diagnosed and undiagnosed individuals to appropriate HIV/AIDS care services. EIIHA focuses on specific, high-risk parent and target groups. HCP will concentrate EIIHA efforts on those LHJs that are most highly impacted by HIV/AIDS and, as such, have other OA-funded outreach and/or prevention programs with which to collaborate.

HCP Contractors, also funded for Prevention, must ensure their HCP budgets fund one or more service providers to provide one or both of the allowable EIIHA service categories:

- Outreach Services; and/or
- Early Intervention Services (EIS).

All HCP Contractors, NOT funded for Prevention, may still budget for Outreach Services and/or EIS if these services are needed in their communities. For more information about the EIIHA initiative, planning requirements, or EIIHA service category definitions, please refer to the HCP/MAI Program Guidance.

Note: The HCP/MAI Program Guidance also provides information on submitting your EIIHA plan, which is required annually with your budgets.

Required Budget Documents

All budget documents are available as a Microsoft Excel file with a tab for each of the required documents listed below. Contractors must submit budgets using the correct budget forms. [Click here](#) or go to <http://www.cdph.ca.gov/programs/aids/Pages/HCPForms.aspx> to access the HCP and MAI Budget forms.

Document Checklist

Non-Personnel Description

Provide an explanation/justification to describe what is included in the Non-Personnel Costs.

Contractor Agency Locations

When the Contractor is also the Service Provider to identify where services are being provided for monitoring.

Service Provider Agency Locations

Include sub-subcontracted Service Providers when the initial subcontracted Service Provider is the Fiscal Intermediary only.

Contractor Contact Information

Complete all fields and include DUNS #

Five Line Item Budgets

Budget Overview

Form A

Contractor Administrative Budget Summary, submitted annually as noted above.

Form B

Contractor Administrative Personnel Detail, submitted annually as noted above.

Form C

Needs Assessment Detail (not required for MAI), submitted and budgeted for Year 1 of each three-year contract period, and not to exceed 5 percent of a Contractors total three-year allocation.

<i>Form D</i>	Client Service Provider Budget Summary, submitted annually as noted above, if the contractor is also a Service Provider.
<i>Form E</i>	Client Service Provider Personnel Detail, submitted annually as noted above, if the contractor is also a Service Provider. List ALL sources of funding for MAI Outreach Workers on the MAI budget Form E.
<i>Form F</i>	Subcontracted Service Providers who utilize subcontracts to fund other entities to provide HCP services Must Complete this form for each entity.

Note: Multiple Forms for *D and E* are to be submitted if more than one Client Service Provider will be funded.

If, due to the Request for Proposal/Request for Application process for subcontracted Service Providers, *Forms D and E* cannot be completed by the due date, please notify your OA Care Operations Advisor to request approval for an extension of the *Forms D and E* only.

Definition of Contractor's Role versus Service Provider's Role is noted below.

Contractor:

The entity that has entered into a contractual agreement with OA to carry out the administrative activities of HCP such as disbursing program funds, developing reimbursement and accounting systems, contract monitoring, etc.

Service Provider:

The entity that has entered into a contractual agreement to provide direct HCP client services for OA. The entity can be the Contractor and/or Subcontractor who provides direct client services for HCP.

Budget Submittal Requirements

At the start of a new contract term, all Contractors are required to submit a five line item budget with budget details for each contract year as noted below for both HCP and MAI

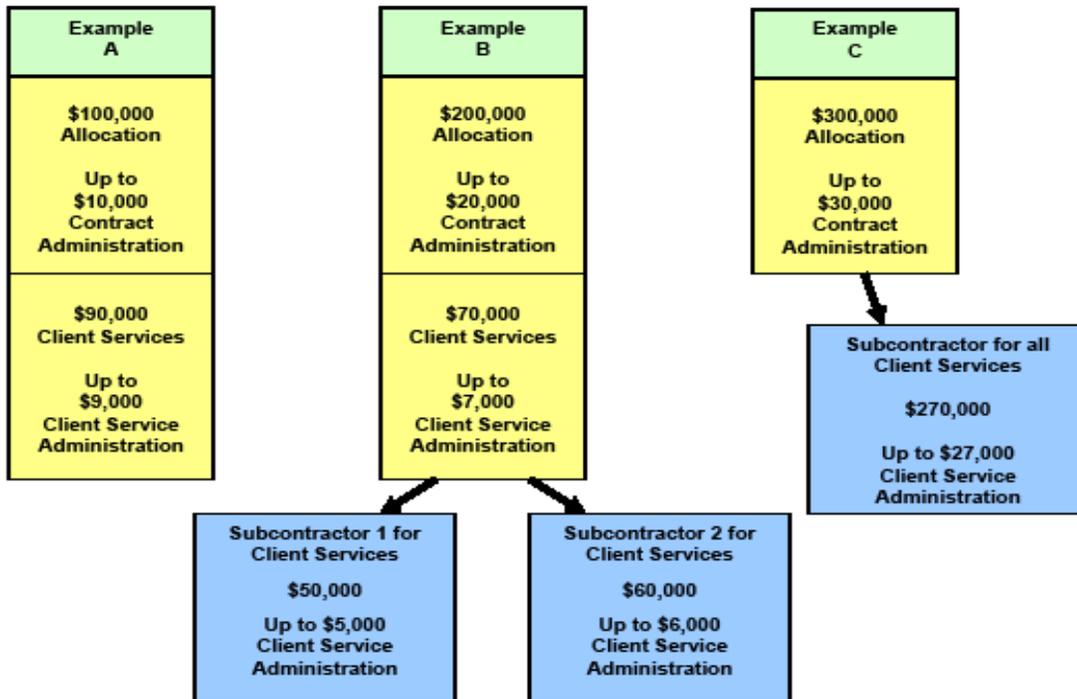
(if applicable). Below are instructions on how to complete a five line item budget each year over a three-year contract period.

In Contract Period...	Submit Five Line Item Budget for...	and Budget Details for...
Year 1	Year 1, 2, and 3	Year 1
Year 2	Year 2 and 3	Year 2
Year 3	Year 3	Year 3

Note: Year 3 (FY 2012-13) is requested at this time. Contractors are required to submit a five line item budget, including Budget Details, for Year 3.

Administrative Cost Allowances

HCP (and MAI, If Applicable) Administrative Costs Allowances



All Contractors may use up to 10 percent of their total allocation for contract administration. In addition:

Example A: If the Contractor provides all client services, the Contractor may take up to 10 percent of the client service allocation for client service administration.

Example B: If the Contractor provides client services and also subcontracts for additional client services, the Contractor may take up to 10 percent of the Contractor's client service allocation for client service administration. Each Subcontractor may also take up to 10 percent of their client service allocation for client service administration.

Example C: If the Contractor subcontracts for the provision of all client services, each Subcontractor may take up to 10 percent of their client service allocation for client service administration.

NOTE: Service provider administrative costs (whether contractor or subcontracted) should not exceed 10 percent without justification and approval by OA.

General Budget Definitions

Please adhere to the following definitions when completing the Contractor and Service Provider Budget Documents.

<p>Administrative Costs</p> <p><i>(Please refer to the Administrative Costs Allowances Diagram for additional information.)</i></p>	<p>The sum of Administrative Personnel, Operating Capital, and Indirect Costs. Contractor and Service Providers cannot exceed 10 percent of their total allocation without justification and management approval from HCP.</p> <p>Note: Please be sure to contact your OA Care Operations Advisor if you would like to request more than 10 percent allocation to Administrative Costs</p> <p>Note: A receptionist that assists clients and directs phone inquiries for single or multiple programs is Administrative Personnel and is not to be charged as a service category cost. A receptionist is an Administrative function.</p>
<p>Personnel</p>	<p>Contractor and Service Providers total salaries, wages, benefits, and travel paid to staff providing administrative support and costs associated with staff providing direct client services.</p>
<p>Non-Personnel</p>	<p>Service Providers allowable expenses associated with providing direct client care (supplies, materials, medical equipment, nutritional supplements, lab tests, food, and transportation vouchers, etc.)</p> <p>Note: For all non-personnel costs budgeted, include a detailed justification with an itemized list of items included.</p>
<p>Operating Expenses</p>	<p>Contractor and Service Providers Operating Expenses for program operations may include non-personnel costs, office supplies, postage, facilities, telephone, Internet connection, encryption software, minor equipment (unit cost under \$5,000), and travel, etc.</p> <p>Note: Equipment approved and purchased by OA must be tagged, inventoried annually, and reported annually to OA.</p>

<p>Capital Expenses</p>	<p>Includes computers, printers, and other types of equipment, with a unit cost greater than \$5,000. Capital Expenses must be approved by HCP prior to purchase.</p> <p>Note: If requesting Capital Expenses, a written justification must be provided that:</p> <ul style="list-style-type: none"> • Lists the equipment that is being requested; • Explains who will use the equipment and for what purpose; • Explains why it is necessary to purchase the equipment; • Includes a purchase versus lease analysis for “large dollar” items; and • Equipment approved and purchased by OA must be tagged, inventoried annually, and reported annually to OA.
<p>Other Costs</p>	<p>Unique program costs and costs not applicable to any other line item.</p> <p>Other costs include:</p> <ul style="list-style-type: none"> • Contractor (as the Service Provider) non-personnel client services (i.e., food and transportation vouchers, labs, etc.); and • Needs Assessment costs and all subcontracted client Service Provider costs.
<p>Indirect Expenses</p>	<p>Typical indirect expenses are costs that cannot be assigned to one program. Often this category is used when a Contractor has multiple programs and divides the rent, utilities, janitorial services, payroll accounting, etc., either equally between programs or based on the percentage of time spent on a program.</p> <p>Note: Indirect Expenses are limited to 15 percent of Personnel Expenses. Contractors cannot exceed 15 percent of their total Administrative Personnel and Client Service Providers cannot exceed 15 percent of their personnel.</p>

Budget Instructions and Definitions

Contractors should consider the impact of the Affordable Care Act on program services for FY 2012-13 when developing the budget. Services funded in the past may not need to be funded at the same level as some HCP clients will transition to other programs. OA expects Contractors to assess any savings in outpatient ambulatory medical services and redirect other Tier II categories of services that represent highest need. It is critical that Contractors complete program plans based on the instructions in the HCP/MAI Program Guidance ensure and appropriate budget.

Below are instructions on how to complete budget documents.

- a) Complete all budget forms, including filling out all check boxes;
- b) Include a billing address, if it differs from the mailing address;
- c) Include the Contractor DUNS # where indicated;
- d) Round all figures to the nearest whole dollar;
- e) Provide description/explanation of all **non-personnel** funds to show the activities those funds will be used for;
- f) Provide contracted and subcontracted service provider agency locations/addresses where client charts are case managed and screened for eligibility;
- g) Submit the forms to the assigned OA Care Operations Advisor on or before each specified due date; and
- h) Refer to the instructions below to complete the budget documents identified in the corresponding tab on the Excel spreadsheet.

Document Checklist: The Document Checklist (and MAI Document Checklist, if applicable) must be completed by the Contractor to certify that all required budget documents have been accurately completed and submitted in a timely manner as per OA's HCP deadlines.

Non-Personnel Information: Service Provider Non-Personnel funds provided on Form D need to be explained here. Provide an explanation to describe what is included in the Non-Personnel expenses that require funds from HCP. An explanation and/or bulleted list of items to support Non-Personnel funds are required.

Contractor Agency Location List (when Contractor is also the Service Provider): List all Contractor Agency locations where Contractor provides direct services. If Contractor is a Fiscal Agent only and subcontracts out direct services, indicate Fiscal Agent Not Applicable below. This is required for scheduling annual site visits and completing the annual HRSA RW Services Report (RSR). Identify all Administrative Agency Offices where client charts reside for case management and eligibility screening documentation is included.

Service Provider Agency Location List (Include sub-subcontractors when initial subcontracted Service Provider is a Fiscal Intermediary only): List all subcontracted Service Provider Agency Locations. If Service Provider is a fiscal intermediary only, list all sub-subcontracted Service Provider Agency and locations. This information is required for scheduling annual site visits and completing the annual HRSA RSR. Identify all Administrative Agency Offices where client charts reside for case management and eligibility screening documentation is included.

Contractor Contact Information: The Contractor Contact Information (and MAI Contractor Contact Information) form provides HCP with the Contractor's staff names responsible for daily programmatic and fiscal operations. Notify your assigned OA Care Operations Advisor of any changes to the Contractor's contact information.

Five Line Item Budget Definitions

All Contractors are required to submit a five line item budget for the duration of the three-year contract term for each contract year with the understanding that the individual line items (budget details) are submitted annually.

Personnel Expenses: Include LHJ or CBO staff costs and are the sum of Contractor -Total Administrative Personnel (Form A), and Contractor's Total Personnel Expenses (Form E), if the Contractor is also, listed as a Service Provider.

Note: Please ensure that the Contractor's Administrative Costs and the Total Contractor Administrative Budget on Form A under Contractor Administrative Budget Summary, does not exceed 10 percent of the total administrative allocation.

Operating Expenses: Operating expenses are the Contractor's costs and are the sum of operating costs on Form A and operating costs on Contractor's Form D, if the Contractor is also a Service Provider.

Capital Expenses: Are the Contractor's costs and the sum of capital expenses (Form A) and capital expenses on Contractor's (Form D), if the Contractor is also listed as a Service Provider.

Other Costs: Includes the sum of the total Contractor's needs assessment budget on Form C, any non-personnel client services (e.g., transportation vouchers) on Contractor's Form D, including the total of subcontracted Client Service Provider budgets on Form D.

Indirect Expenses: Are the Contractor's costs and the sum of Indirect Costs on Form A, and indirect costs on Contractor's Form D, if the Contractor is also listed as a Service Provider.

Budget Detail Forms Definitions

Budget Overview Form: Indicates how the total allocation of funds is distributed between the Contractor and Client Service Provider(s).

- a) Enter the budget amounts for Client Service Provider Costs (whether provided by a Contractor and/or subcontracted agency).
- b) The Contractor Costs and Needs Assessment Costs fields on the form will automatically update when Forms A and C are completed.
- c) The Budget Overview Form(s) must equal the total allocation

Form A - Contractor Administrative Budget Summary: Identifies the Contractor and itemizes expenses. Complete Form A as follows:

- a) Complete the Total Administrative Personnel, Operating Expenses, and Indirect Expenses;
- b) Itemize any Operating Expenses or Indirect Costs;
- c) Include a written justification, if using the Capital Expenses line item;
- d) Ensure Indirect Expenses do not exceed 15 percent of total Administrative Personnel Expenses;
- e) The Total Administrative Personnel Expenses identified on Form A is equal to the sum of the Total Personnel Expenses on Form B; and
- f) Ensure total Contractor administrative costs do not exceed 10 percent of the total allocation. The 10 percent calculation for the Contractors Administrative Budget on Form A will be calculated once the five line item budget form has been completed.

Form B - Contractor Administrative Personnel Detail: Contractor Administrative Personnel Detail identifies the personnel providing administrative services including staff salaries. Complete Form B as follows:

- a) Complete Contractor information;
- b) Describe the duties of each employee and including justification of job-required travel (e.g., training);
- c) Complete either the "Annual Salary" or "Hourly Salary" box and the "Salary paid by this contract" box for each employee;
- d) If travel is required, enter the estimated travel expense;
- e) Enter the Benefits, if any, for each employee;
- f) Make additional copies of this form if there are more than four employees; and

- g) The Total Administrative Personnel Costs identified on Form A is equal to the sum of the Total Personnel Expenses on Form B.

Form C - Needs Assessment Detail (not required or applicable for MAI):

Contractors are required to conduct a full needs assessment at least once during the three-year contract period and is required as part of the Service Delivery Plan (SDP).

Note: Form C needs to be completed whether you are conducting the Needs Assessment directly or through a subcontracted agency.

Form C must include the following:

- a) Describe the duties of the person conducting the Needs Assessment and include details about any travel associated with the Needs Assessment;
- b) Ensure the total Needs Assessment budget does not exceed 5 percent of the total contract allocation;
- c) Ensure the contract start date corresponds with the actual date the work begins on the Needs Assessment; and
- d) Report the Needs Assessment costs under "Other Costs" on the five line item budget. A sample of the Needs Assessment Detail can be found at the end of this document.

Note: A copy of the Needs Assessment must be sent to your OA Care Operations Advisor within 45 days of completion. HCP Contractors in Eligible Metropolitan Areas or Transitional Grant Areas can submit their Planning Council's Comprehensive Plan in lieu of the SDP (and Needs Assessment). The use of HCP funds is prohibited for the Needs Assessment when a Comprehensive Plan is submitted.

Form D - Client Service Provider Budget Summary: Provides information regarding the estimated number of clients to be served, the costs of administrative and direct client services, and indirect and operating expenses.

Note: Form D is required for each Client Service Provider, whether services are subcontracted or provided by the Contractor.

Form D must include the following:

- a) The Client Service Costs completed with the exact HRSA category as allowable for HCP Tier I Core Medical Services and Tier II Support Services (MAI service categories, if applicable). (Click the drop-down box under Services and select the appropriate category.);
- b) Include the personnel and non-personnel amounts for each category (for example, Outpatient/Ambulatory Medical Care may have personnel costs as well as non-personnel costs such as labs;

- c) A copy of the policy and tracking method if funding Emergency Financial Assistance;
- d) The estimated number of unduplicated clients to be served; and
- e) The Administrative Personnel Expense, Operating, Capital, and Indirect Expense categories as instructed in the Definitions for Budget Documents.

Note: Written justifications must be provided for the following items:

- a) Non-personnel amounts submitted to explain what those amounts are going to be used for;
- b) Service Provider's administrative costs exceed 10 percent of the Service Provider's allocation;
- c) Capital Expense line item is greater than zero (see Definitions for Budget Documents);
- d) Client Service Provider was sole sourced; or
- e) Total Administrative Personnel is equal to the sum of Form E administrative staff salaries, travel, and benefits.

Form E - Client Service Provider Personnel Detail: This form provides information on administrative staff and staff that provides services directly to clients. Form E is required for each Client Service Provider, whether services are subcontracted or provided by the Contractor. Form E must include the following:

- a) Describe the duties of each employee;
- b) Include details about job-required travel (e.g., client-related travel, training, etc.);
- c) If travel is required, enter the estimated travel expense;
- d) Complete two position sections for any staff whose duties are split between Administrative and Direct Client Service and "yes" or "no" under "Is this an administrative position?";
- e) Use State's per diem reimbursement rates to estimate travel expenses;
- f) Complete either the "Annual Salary" or "Hourly Salary" box and the "Salary paid by this contract" box for each employee;
- g) Enter the Benefits, if any, for each employee;
- h) Enter exact name of HRSA Client Service Category provided by employee (click on the drop-down box next to "HRSA Service Category" and select the appropriate service category or click on "N/A - Administrative Position" for administrative staff); and
- i) Make additional copies of this form if there are more than four employees.

Form F - HCP Client Service Provider: This form provides information on subcontracted Service Providers who utilize subcontracts to fund other entities to provide HCP services. This form must be complete for each entity.

Line Item Shifts and Budget Revisions

Contractors should continuously assess their budgets and shift money based on expenditures and need. Line Item Shifts and Budget Revisions can occur quarterly to assist Contractors in moving funds to accommodate the service needs of their LHJs.

Line Item Shifts: Contractors are allowed line item shifts up to **15 percent**, if it does not increase or decrease the annual contract total amount. Additionally, Contractors are allowed to revise dollar amounts, service categories, and service provider information as needed. In order to make a line item shift and/or budget revision, the Contractors are required to submit required budget documents to their OA Care Operations Advisor.

Budget Revisions: Service Provider subcontracted dollar amounts are reported in the "Other Costs" line item and, therefore, are not considered line item changes. Service Providers that are subcontracted must notify the Contractor of any budget shifts or changes in services and/or allocations. It is the responsibility of the Contractor to notify their assigned OA Care Operations Advisor, and provide a revised budget packet, before the budget revisions can be implemented.

Note:

- The revised budget packet must include all budget forms and required changes, showing each line item that has been impacted, a revised Summary Tracking Form, and a justification for the revision.
- Changes, additions, and/or deletions of Service Providers must also be submitted as a budget revision to your assigned OA Care Operations Advisor. This information will be used to update the services for each provider's HCP "contract" in the AIDS Regional Information and Evaluation System (ARIES).
- ARIES contracts must mirror the most recent budgets so that providers collect and report their funded services on their annual RSR.

Section 2. Invoicing

Contractors must submit invoices for reimbursement of expenses incurred on a monthly or quarterly basis. Invoices must be based on actual expenses incurred within the month/quarter specified, and the expenses claimed must be from the approved budget.

Invoice Submittal Requirements

Invoices are due to OA HCP 45 days following the end of each billing period. When submitting the monthly or quarterly invoice, Contractors are required to include HCP/MAI Summary Tracking and HCP Quarterly Financial Reports which provide data required by HRSA for OA reporting.

Note: MAI does not submit Quarterly Financial Reports.

Section 3. Reporting

Contractors are required to submit Quarterly Narrative Reports for HCP and/or MAI (if applicable) to their assigned OA Care Operations Advisor. The Quarterly Financial Report and the HCP/MAI Summary Tracking are submitted with invoices to the OA Invoice Desk, as referred to in the Scope of Work.

Financial Reports

Contractors are required to submit their HCP/MAI Summary Tracking and HCP Quarterly Financial Reports with their invoices to the OA Invoice Desk. They will be routed to the HCP Fiscal Analyst for review and reimbursement processing.

HCP Quarterly Financial Report	Tracks expenditures to date for the contractor and any subcontracted Service Providers; includes the total number of unduplicated clients served by each Service Provider. Contractors must pull client counts from ARIES to include in the financial report. For assistance in obtaining this information from ARIES, contact the ARIES Help Desk at 1 (866) 411-2743.
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HCP/MAI Summary Tracking Report	Tracks expenditures to date in budgeted service categories.
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Note: Contractors submitting invoices monthly must submit their Quarterly Financial Reports by the due dates below.

Narrative Reports

The Quarterly Narrative Report is an opportunity for Contractors to describe general accomplishments, to raise issues or concerns, and to request any technical assistance and/or training needs.

Quarterly Narrative Report due dates are:

Reporting and Invoicing Period	Due Date
July 1 – September 30	November 15
October 1 – December 31	February 15
January 1 – March 31	May 15
April 1 – June 30	August 15

Note: If the due date falls on a weekend, the narrative report is due the following Monday. Contact your OA Care Operations Advisor for the most current reporting forms.

Note: It is recommended to include if there have been any changes to your county Low Income Health Program and indicate what those changes are.

Section 4. Contract Performance Monitoring

In 2011, HRSA released the RW HIV/AIDS Program Part B National Monitoring Standards and subsequently, OA revised monitoring tools and internal processes. Contract performance monitoring will be performed in accordance to HRSA's National Monitoring Standards which can be reviewed on HRSA's website located at:

<http://hab.hrsa.gov/manageyourgrant/granteebasics.html> or by contacting your OA Care Operations Advisor.

Performance Monitoring Process

OA monitors Contractor and Service Provider performance through a variety of methods. OA continuously reviews and monitors fiscal, programmatic, and administrative performance through Contractor and Service Provider budgets, invoices, narrative reports, fiscal reports, site visit activities, SDPs, and needs assessments.

Contract Monitoring Surveys

OA utilizes several data reports and tools generated from ARIES that assist in regular monitoring of Contractor and provider compliance and include:

1. Data Monitoring and Evaluation Report - Summarizes key data elements for all the HCP clients the provider served during the FY. The selected data elements include: proof of HIV diagnosis, insurance status, federal poverty level, "share" status and consent, estimated and actual number of clients served by service category. The report identifies areas that need improvement.
2. HCP Chart Selection Report - A tool to provide a random list of clients who received at least one HCP service in the FY being monitored. Contractors are required to generate the list from ARIES, and have the charts available, in preparation for annual site visits which will be used by OA Care Operations Advisors when conducting chart reviews.
3. Client Chart Review – OA Care Operations Advisors review the charts for documentation of eligibility that includes: client name, intake information, proof of HIV status, selected forms (e.g., ARIES Share Consent form, client rights, grievance procedures, etc.), financial status (e.g., proof of income, employment, payer of last resort, etc.). Time required to review each chart depends on the chart complexity and organization.

Site Visits

The purpose of the on-site visit is to verify contractual compliance with the monitoring standards and to provide needed technical assistance. Site visits and other monitoring activities will occur during the grant year between April 1 and March 31. The OA Care Operations Advisors will contact each LHJ/CBO to schedule a site visit as required. OA reserves the right to disapprove the selection of Service Providers to be visited that do not comply with the standards set forth by HRSA and OA criteria.

Site Visit Scheduling/Process

OA utilizes the following process as to schedule site visits. Contractors are required to work with OA to manage and adhere to the process below as much as possible. OA is responsible to ensure all Contractors and Service Providers receive a site visit annually and will work collaboratively with Contractors to ensure the requirement is met for service providers within their LHJ. Contractors who do not have the capacity to complete site visits of their Service Providers annually must contact their OA Care Operations Advisor to arrange assistance.

VERBAL NOTIFICATION	60 days
ENTRANCE LETTER	45 days
CONTRACT REVIEW	30 days
ONSITE MONITORING	SCHEDULE DATE
REPORT COMPLETE or CAP REQUESTED	30 days
CAP REPORT DUE	30 days
CAP APPROVAL/FILE UPDATE	60 days

Corrective Action Plans (CAP)

OA Care Operations Advisors require Contractors to develop and implement a CAP to address deficiencies found during the site monitoring visits and chart review process. The CAP is due 15 days after receiving a completed site monitoring report from OA. OA Care Operations Advisors will follow up to ensure that the CAP has been implemented

Annual Audits

OA contracts are audited annually by the Audits and Investigations (A&I) Branch of the California Department of Health Care Services. HCP and MAI contracts are audited by A&I at least once during the three-year contract term. New Contractors are audited after completing the first contract year.

Note: The Monitoring and CAP processes noted above helps ensure local HIV care providers comply with the HCP contract and minimize potential fiscal findings and recovery reports by A&I.

Section 5. Links to Forms and Other Resources

Click on any of the links below to access information on OA's website:

HCP website at:

<http://www.cdph.ca.gov/programs/aids/Pages/tOACareProviders.aspx>.

HRSA RW Legislation at: <http://hab.hrsa.gov/about/legislation.html>.

HRSA Title II Manual at:

<http://cdphinternet/programs/aids/Documents/HCPRWCTitleIIManual.pdf>.

HRSA National Monitoring Standards (at the bottom of the page) at:

<http://hab.hrsa.gov/manageyourgrant/granteebasics.html>.

(APPENDIX A) TIER I - CORE MEDICAL SERVICES

Outpatient/Ambulatory Medical Care (health services)

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 his or her jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight.

Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive 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 care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

Note: EIS provided by RW Parts C and D programs are reported under outpatient/ambulatory medical care.

Local AIDS Pharmaceutical Assistance (APA, not ADAP)

Includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. These organizations may or may not provide other services (e.g., outpatient/ambulatory medical care or case management) to the clients they serve through a RW 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:

- Have a client enrollment process;
- Have uniform benefits for all enrolled clients;
- Have a record system for distributed medications; and
- Have a drug distribution system.

Programs are not APAs if they dispense medications in one of the following situations:

- As a result or component of a primary medical visit;
- On an emergency basis (defined as a single occurrence of short duration); or
- By giving vouchers to a client to procure medications.

Note: Local APAs are similar to 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.

Oral Health Care

Includes diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide health care in the State or LHJ, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained dental assistants.

EIS

Counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and 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 provision of therapeutic measures.

Note: EIIHA activities should be reported under EIS (HCP) and/or Outreach (MAI) service categories.

Health Insurance
Premium and Cost
Sharing Assistance

The 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, co-payments, and deductibles. Under this service category, funds may be used as the payer of last resort to cover the cost of public or private health insurance premiums, including insurance deductible and co-payments.

Important: Grantees should refer to the [HAB Policy Notice-07-05](#), "The Use of Ryan White HIV/AIDS Program Part B ADAP Funds to Purchase Health Insurance."

Home Health
Care Services

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.

Home and
Community-Base
Services

Include 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.

Note: Inpatient hospitals services, nursing home, and other long-term care facilities are not home- and community-based services.

Hospice Services

Include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Funds may be used to pay for hospice care by providers licensed in the state, in which services are delivered. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of six months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid programs.

Mental Health Services

Include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the state (i.e., psychiatrists, psychologists, and licensed clinical social workers).

Note: Mental health services provided to HIV-affected clients should be reported as psychosocial support services.

Medical Nutrition Therapy

Services provided by a licensed registered dietitian outside of an outpatient/ambulatory medical care visit. The provision of food may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian. Nutritional services and nutritional supplements

not provided by a licensed, registered dietician shall be considered a support service and be reported under psychosocial support services and food bank/home-delivered meals respectively. Food not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician should also be considered a support service and is reported under food bank/home-delivered meals.

Medical Case Management Services (including treatment adherence)

A range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. The coordination and follow up of medical treatments are 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 assessment of the client 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:

- Initial assessment of service needs;
- Development of a comprehensive, individualized service plan;
- Coordination of services required to implement the plan;
- Client monitoring to assess the efficacy of the plan; and
- Periodic reevaluation and adaptation of the plan, at least every six months, as necessary over the life of the client.

It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face, telephone, and any other forms of communication.

Note: Medical case management is provided by dedicated professionals with nursing degrees, masters in social work, health care staff and, in some cases, no degree but the knowledge only life experience can bring.

Substance Abuse Services (outpatient)

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 by a physician or under the supervision of a physician, or by other qualified personnel.

Such services should be limited to the following:

- Pre-treatment/recovery readiness programs;
- Harm reduction;
- Mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse;
- Outpatient drug-free treatment and counseling;
- Opiate assisted therapy;
- Neuro-psychiatric pharmaceuticals; and
- Relapse prevention.

Note: They include limited support of acupuncture services to HIV-positive clients provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists.

(APPENDIX B) TIER II - SUPPORT SERVICES

Case Management
(non-medical)

Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow up of medical treatments.

Child Care Services

The provision of care for the children of clients who are HIV positive while the clients attend medical or other appointments or RW Program-related meetings, groups, or training. This does not include child care while a client is at work.

Emergency Financial
Assistance

The provision of one-time or short-term payments to agencies or the establishment of voucher programs when other resources are not available to help with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), transportation, and medication. Part A and Part B programs must allocate, track, and report these funds under specific service categories, as described under 2.6 in DSS Program Policy Guidance No. 2 (formerly Policy No. 97-02).

Note: It is expected that all other sources of funding in the community for emergency assistance will be effectively utilized and that any allocation of RW HIV/AIDS Program funds to these purposes will be the payer-of-last-resort, and for limited amounts, use and periods of time. Continuous provision of an allowable service to a client should be reported in the applicable service category.

Food
Bank/Home-Delivered
Meals

The provision of actual food or meals. Food vouchers provided as an ongoing service to a client are included in this category. Purchasing food or meals is NOT allowed under this service category.

The provision of essential household supplies, such as hygiene items and household cleaning supplies and food and/or nutritional supplements provided by someone other than a registered dietician should be included in this item.

Note: Food vouchers provided on a one-time or intermittent basis should be reported in the emergency financial assistance category.

Health
Education/Risk
Reduction

Activities that educate clients living with HIV about HIV transmission and how to reduce the risk of 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.

Health education/risk reduction services cannot be delivered anonymously; client level data must be reported for every individual that receives this service. Health education/risk reduction services can only be delivered to individuals who are HIV positive.

Note: Syringe Service Programs and/or Syringe Exchange Programs are no longer RW federally funded.

Housing Services

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. Eligible housing can include both housing that provides some type of medical or supportive services, such as residential substance abuse or mental health services, residential foster care, or assisted living residential services and housing that does not provide direct medical or supportive services but is essential for an individual or family to gain or maintain access to and compliance with HIV-related medical care and treatment.

Short-term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable living situation. Therefore, such a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of assistance cannot be permanent and must be accompanied by maintaining, a long-term, stable living situation. For more information, see the policy “The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services

and Short-term or Emergency Housing Needs” at:
<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>.

Note: Housing funds cannot be in the form of direct cash payments to recipients and cannot be used for mortgage payments. Permanent living situations are not funded under this service category, for permanent housing options refer to Housing Opportunity for People with HIV/AIDS.

Legal Services

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 RW HIV/AIDS Program.

Note: Legal services to arrange for guardianship or adoption of children after the death of their primary caregiver should be reported as a permanency planning service.

Linguistic Services

Include the provision of interpretation (oral) and translation (written) services provided by qualified individuals as a component of HIV service delivery between the provider and client, only when such services are necessary to support the delivery of RW-eligible services.

Medical Transportation Services

Conveyance services provided, directly or through a voucher, to a client so that he or she may access health care services.

Outreach Services

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. 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; targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; conducted at times and in places where there is a

high probability of reaching individuals with HIV infection; and designed with quantified program reporting that will accommodate local effectiveness evaluation.

Note: Outreach services do not include HIV counseling and testing or HIV prevention education. Broad activities such as providing "leaflets at a subway stop" or "a poster at a bus shelter" or "tabling at a health fair" would not meet the intent of the law. EIIHA activities can be reported under this service category and/or EIS.

Permanency
Planning

Services to help clients/families make decisions about the placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them. It includes the provision of social service counseling or legal counsel regarding: 1) the drafting of wills or delegating powers of attorney; and 2) preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.

Psychosocial
Services

The provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Psychosocial support services include nutrition counseling provided by a non-registered dietitian, but exclude the provision of nutritional supplements.

Note: Nutritional services and nutritional supplements provided by a licensed, registered dietician are considered a core medical service and should be reported as Medical nutrition therapy. The provision of food and/or nutritional supplements by someone other than a registered dietician should be reported in the food bank/home-delivered meals service category.

Referral for Health
Care/Supportive
Services

The act of directing a client to a service in person or writing, by telephone, or other type of communication. These services are provided outside of an outpatient/ambulatory medical care, medical case management, or non-medical case management service visit.

Note: Referrals for health care/supportive services provided by outpatient/ambulatory medical care providers should be reported under the outpatient/ambulatory medical care service category.

Note: Referrals for health care/supportive services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., medical case management or non-medical case management).

Rehabilitation Services

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.

Respite Care

The 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.

Substance Abuse Services (residential)

The provision of treatment to address substance abuse issues/needs (including alcohol and/or legal and illegal drugs) in a residential health service setting (short term).

Note: Funds may not be used for inpatient detoxification in a hospital setting. Substance Abuse Services include limited support of acupuncture services to HIV-positive clients provided the client has received a written referral from his or her primary health care provider, and the service is provided by a certified or licensed practitioner and/or program, wherever the State certification or licensure exists.

Treatment Adherence Counseling

Counseling or special programs provided outside of a medical case management or outpatient/ambulatory medical care visit by non-medical personnel to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Treatment adherence counseling provided during an outpatient/ambulatory care service visit should be reported under the outpatient/ambulatory

medical care service category. Likewise, treatment adherence counseling provided during a medical case management visits should be reported in the Medical Case Management Service category.

Note: This service is provided outside of a medical case management or outpatient/ambulatory medical care visit and clinical setting by non-medical staff.

(APPENDIX C) - UNALLOWABLE COSTS

Most of the unallowable costs have been addressed in each service category described in Appendix A, however, there are additional unallowable costs for Part B funds, including, but not limited to:

- Conferences are not an allowable expense under the Ryan White Part B Grant;
- Under **no** circumstances may service providers use HCP or other OA funds to develop or maintain a data import to ARIES (see [ARIES Policy Notice G3 – ARIES Imports](#));
- International travel;
- Construction and renovations to personal or commercial buildings;
- Entertainment costs (i.e., amusement parks, social activities, and related incidental costs);
- Fundraising expenses;
- Lobbying expenses;
- Purchasing clothing;
- Maintenance of privately owned vehicles (i.e., tires, repairs, etc.) and other related payments (i.e., lease, loan insurance, license and registration fees). Note: This restriction does not apply to vehicles operated by organizations for HIV/AIDS-related purposes;
- For funeral, burial, cremation, or related expenses;
- Property Taxes (i.e., local or State personal property taxes for residential property, private automobiles, or any other personal property against which taxes may be levied);
- Off-premise recreational activities such as gym membership;
- Payment to attend meetings and conferences such as the National HIV/AIDS Conference; and
- Direct payments of cash to recipients of services. Where direct provision of the service is not possible or effective, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.