The Boston Public Health Commission

Request for Proposals (RFP)

for HIV Client Services

RYAN WHITE HIV/AIDS TREATMENT
EXTENSION ACT PART A
FY 2016

HIV Client Services:
Medical Case Management
Psychosocial Support (Peer Support)
Medical Transportation

HIV/AIDS Services Division
Boston Public Health Commission
1010 Massachusetts Avenue, 2nd Floor
Boston, MA 02118

Section I:
Narrative, Instructions, Attachments

IMPORTANT: Review Changes, Updates, and Clarifications related to RFP Documents by visiting http://www.bphc.org/rfp.
<table>
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<tr>
<th>Date and Time</th>
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<tr>
<td>June 22, 2016 12:00 PM</td>
<td><strong>REQUEST FOR PROPOSAL (RFP) AVAILABLE.</strong> The RFP document may be picked up from the Boston Public Health Commission (BPHC) reception desk, 1010 Massachusetts Avenue, 2nd Floor, Boston, MA 02118. It will also be available online at <a href="http://www.bphc.org/rfp">www.bphc.org/rfp</a>. <strong>The RFP will NOT be mailed to any applicants.</strong></td>
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<td>Tuesday, July 5, 2016 Due by 12:00 PM</td>
<td><strong>LETTER OF INTENT.</strong> Letters of Intent to apply for Part A HIV Health Services funds may be faxed to (857) 288-2194 or emailed to <a href="mailto:ethai@bphc.org">ethai@bphc.org</a> to the attention of Eric Thai, Interim Director, HIV/AIDS Services Division. If the fax is not working or is busy, please call (617) 534-4559 to make other arrangements. A Letter of Intent form is provided in Section II of this RFP.</td>
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<td>July 22-30, 2016</td>
<td><strong>PROPOSAL REVIEW/EVALUATION PERIOD.</strong> Proposals will be reviewed and evaluated using an independent evaluation process.</td>
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<td>August – September 2016</td>
<td><strong>NOTIFICATION OF AWARD.</strong> Letters will be mailed notifying applicants if their proposal will be funded or not.</td>
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<td>September 1, 2016 – February 28, 2017</td>
<td><strong>CONTRACT PERIOD.</strong> The contract period for Ryan White Part A funds under this RFP is September 1, 2016 through February 28, 2017. The contract period after FY 2016 will be for 12 months; contracts will be written with the possibility of a continued extension beyond FY 2016, subject to performance, Federal appropriations and local allocations.</td>
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I. REQUEST FOR PROPOSALS OVERVIEW

A. INTRODUCTION

Through this Request for Proposals (RFP), the Boston Public Health Commission (BPHC) seeks proposals to provide Medical Case Management, Psychosocial Support, and Medical Transportation services that target people living with HIV (PLWH) within the Boston Eligible Metropolitan Area (EMA) (map presented in Appendix A). The goals of these services are to (1) support individuals living with HIV in their efforts to enter into and remain in primary health care and health-related support services and (2) help improve the clinical health outcomes and quality of life of PLWH.

Applicants can apply for more than one service category. Applicants wishing to apply for multiple service categories may submit one proposal with additional sections for each service category. BPHC seeks applications from agencies that will be successful in engaging clients who know their status but are not presently in care, and assisting them in gaining and maintaining access to the HIV Care Continuum (see Appendix C). Services must conform to the Planning Council definition(s) and any relevant Health Resources and Services Administration (HRSA) and BPHC policies. BPHC intends to fund a group of agencies/programs serving populations that are reflective of the epidemiological profile of the EMA (presented in Appendix B); BPHC will fund services in a variety of settings.

This RFP is organized in a manner intended to facilitate the application process. Section I outlines the goals and objectives for the upcoming contract period. In addition, it covers basic eligibility information and the reporting and fiscal requirements that will be expected from agencies should they be funded.

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

The project period for this funding is up to five years: July 1, 2016 – February 28, 2020. The first year of funding under this RFP will be for nine months; each subsequent contract period will be for 12 months. All contracts will be written with the possibility of a continued extension beyond FY 2016 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 and will be reviewed for performance in relation to the contracted goals and objectives, which will be stipulated in the FY 2016 contract.

B. 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 and supplemental funding are intended to develop or to enhance access to a comprehensive continuum of high quality, community-based care for low-income individuals and families infected and affected by HIV disease. 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.

**Eligible Service Region**

The Boston EMA service region includes seven counties in Massachusetts: Bristol, Essex, Middlesex, Plymouth, Norfolk, Suffolk, and Worcester; and three counties in New Hampshire: Hillsborough, Rockingham, and Strafford (see map in Appendix A).

**Grantee and Planning Council Responsibilities**

Part A grants are awarded to each EMA’s Chief Elected Official (CEO). The CEO is the person who is officially designated by Congress to receive Ryan White HIV/AIDS Program fund allocated to the EMA by HRSA. The CEO is also the elected official who is in charge of the major city or county in the EMA that has the largest number of AIDS cases. For the Boston EMA, the CEO is the Mayor of Boston, Mr. Martin J Walsh. As the CEO, Mayor Walsh is responsible for designating a Grantee and appointing an HIV Services Planning Council.

In the Boston EMA, the Grantee is the BPHC, which administers the Part A grant and is responsible for:

- submitting an annual proposal to Health Resources and Services Administration (HRSA) for the Part A award;
- developing a request for proposals (RFP) for HIV services within the EMA;
- developing and implementing a proposal review process;
- granting awards to programs for HIV services;
- writing and monitoring contracts for HIV services; and
- evaluating the performance of contracted agencies.

The Part A Boston EMA HIV Services Planning Council (Planning Council) is the local community planning body which directs the Grantee in its planning and resource allocation processes for the Ryan White Part A funds. The Planning Council also works with the CEO (or his/her designee) and the Grantee to develop a plan for comprehensive services for PLWH and their families within the EMA. In accordance with the Ryan White HIV/AIDS Treatment Extension Act of 2009, the Planning Council’s responsibilities are to:

- determine the size and demographics of PLWH within the EMA;
- conduct a needs assessment process to find out what services are needed, what populations need care, and what gaps exist in the current system of care with particular attention to (1) PLWH who know their HIV status and are not receiving HIV-related services and (2) disparities in access and services among affected sub-populations and historically underserved communities;
- establish priorities for the allocation of funds within the EMA, including how best to meet each such priority and additional factors that the Grantee should consider in allocating funds;
- together with the Grantee develop a comprehensive plan for the organization and delivery of health and support services;
- assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the EMA;
- participate in the development of the Statewide Coordinated Statement of Need initiated by the State public health agency;
- establish methods for obtaining input on community needs and priorities which may include
public meetings, focus groups, and ad-hoc panels; and
- coordinate with Federal grantees that provide HIV-related services within the EMA.

The Ryan White legislation also mandates planning councils to have members from a diversity of groups and organizations. At least one third (33 percent) of the Planning Council members must be PLWH who receive Part A services and are “unaffiliated”, which means PLWH who are not staff, consultants, or Board members of Part A funded agencies. The Planning Council’s composition must reflect the demographics of the HIV epidemic in the EMA, with particular consideration given to disproportionately affected and historically underserved groups and populations.

C. AVAILABLE FUNDS

The FY 2016 federal award amount is unknown at this time. The HIV/AIDS Services Planning Council projects a range of possible funding for services, conditional upon the actual award amount. The funds available for this RFP are not expected to exceed $6,167,149, which is the sum of the largest dollar amount available in the three service categories eligible for this RFP.

For this re-bid, more than $150,000 has been allocated for services targeting Hispanic/Latino PLWH to be provided by eligible applicants.

Based on the Planning Council’s recommendations, Part A funding allocations are as follows:
- A total of $4,669,480 is allocated for Medical Case Management services.
- A total of $803,551 is allocated for Psychosocial Support (Peer Support) services.
- A total of $239,630 is allocated for Medical Transportation services.

BPHC expects the federal award to be announced by March 1, 2016, subject to Congressional appropriation and presidential signature. The available funds for FY 2016 are expected to be similar to the previous fiscal year. Agencies funded under this procurement will receive a pro-rated nine-month contract during FY 2016.

D. ELIGIBLE SERVICES AND TARGET POPULATIONS

Eligible services for this RFP:
Medical Case Management, Psychosocial Support (Peer Support) and Medical Transportation. The Planning Council defines these services as follows:
- **Medical Case Management**: A range of services linking and retaining clients to/with health care, psychosocial, and other services offered in a variety of settings.
- **Psychosocial Support**: Services funded under this category include peer support, where the person providing the psychosocial support is a person infected with HIV and of the client’s self-identified community, psychosocial mental health services, and psychosocial substance abuse. Only the Peer Support subtype is being procured for this RFP.
- **Medical Transportation**: Transportation services provided directly or through a voucher to enable access to health care services.

Eligible target population for this RFP:

The eligible target population for this RFP is all PLWH who reside in the ten-county region of the Boston EMA, and who meet the BPHC HIV/AIDS Services Division (HASD) Ryan White Part A services income eligibility guidelines. The income eligibility guidelines 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 (currently $4,160 per dependent).

For this re-bid, the proposed target population must be greater than 50% Hispanic/Latino PLWH. Demographics of the target population must be indicated under Table E of Section II: Application.

E. ELIGIBILITY REQUIREMENTS

To be eligible for a Part A award, applicants must meet all of 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 budget of at least $500,000 for eligibility to directly apply for Part A funding. Agencies with an annual operating budget of less than $500,000 may apply only through a sponsor agency which meets the requirement. The sponsor agency will apply as the lead agency with a clearly defined relationship for fiscal oversight and programmatic compatibility.
- Submit a copy of the agency’s most recent single independent audit (for agencies that receive $750,000 or more in Federal funds) or internal audit (for those that receive less than $750,000 in Federal funds).
- Be proposing to provide services to PLWH in the EMA.
- Be in full program/fiscal reporting compliance (currently funded service providers only).

Additionally, programs will need to demonstrate that they:

- Are located in or near to the targeted community they are intending to serve.
- Have a documented history of providing service to the targeted community (ies).
- Have documented linkages to the targeted populations.
- Provide services in a manner that is culturally competent and linguistically appropriate.
- Can demonstrate capacity to document and report service delivery to BPHC and HRSA in accordance with applicable guidelines.

Part A Minority AIDS Initiative (MAI)

For this re-bid, only applicants that meet the requirements for Minority AIDS Initiative funding will be considered for funding.

Under BPHC Ryan White Part A, additional funds are available under the Part A MAI program. These resources, as directed by the Planning Council, will be utilized for Medical Case Management and Psychosocial Support (Peer Support) services provided by eligible applicants to eligible populations. Services provided under Part A MAI funds are for Black and/or Hispanic individuals. Applicants are not required to indicate intent to bid for MAI funding. Eligibility for MAI funds will be determined based on the documentation submitted; BPHC will identify a subset of successful applicants for Ryan White MAI funding based on the following definition of a minority provider:
• Have a board or governing body consisting of greater than 50% minorities;
• Have a professional staff consisting of greater than 50% minorities; and
• Have a current client base consisting of greater than 50% minorities.

Additionally, those applicants funded with MAI resources will need to demonstrate that they have the following qualifications:

• Are located in or near to the community(ies) they are intending to serve;
• Have a documented history of providing service to the community(ies) they intend to serve;
• Have documented linkages to the intended populations, so that they can help close the gap in access to service for highly impacted communities of color; and
• Provide services in a manner that is culturally competent and linguistically appropriate.

F. PAYER OF LAST RESORT

In accordance with Federal policy:

• 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.

• Ryan White funds may not be used to pay for Medicaid covered services for Medicaid beneficiaries.

• Ryan White providers who provide Medicaid covered services must be Medicaid certified.

• Ryan White providers are expected to vigorously pursue Medicaid enrollment for individuals who are eligible for Medicaid coverage.

• Ryan White providers must seek payment from Medicaid when they provide a Medicaid covered service for a Medicaid beneficiary.

• Ryan White providers must bill Medicaid for any Ryan White funded services provided to Medicaid eligible clients once Medicaid eligibility is determined.

Providers must exhaust mandatory Medicaid dollars before accessing Ryan White funds. Applicants are reminded that Ryan White programs are subject to audit and established funding restrictions.

G. FUNDING CYCLE

The funding cycle for programs funded under this RFP will be a maximum of five years (FY 2016 – FY 2020) with annual contract extensions based on performance, Federal appropriations, and local allocations. BPHC reserves the right to put services up for bid sooner and/or to extend contracts beyond the 5-year project period.

H. SCOPE OF SERVICES

Agencies that are funded through the RFP will be issued a Scope of Services as part of their contract package. The Scope of Services is derived from the approved elements of the original proposal and is a
description of the program’s stated goals and objectives. It will include the following items: a
description of the program and the service that will be provided; the target population; the geographic
area; the number of clients to be served; the number of units to be provided; and, all conditions that
apply to the contract.

I. RFP PROCESS

BPHC is responsible for all RFP operations including producing the RFP, communications with
applicant agencies, conducting an independent review of proposals, issuing contracts to awarded
agencies, 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 potential applicants either in person at BPHC or online at
www.bphc.org/rfp. A Bidders’ Conference will be held the week following the release of the RFP to
review the document and to answer any questions from potential applicants. Following the Bidders’
Conference, BPHC staff will not communicate with any potential applicant regarding the service
category content of the RFP. Agencies are also expected to submit a Letter of Intent to BPHC describing
their interest to apply for Part A funds. An independent review committee will review proposals and
make recommendations to the Grantee. Following an internal review process, notification of the award
decisions will then be mailed to each applicant.
A timetable for the FY 2016 HIV Health Services RFP Process follows:

**Wednesday, June 16, 2016**  
RFP Available 12:00 PM

The RFP document may be picked up from BPHC’s reception desk, 1010 Massachusetts Avenue, 2nd Floor, Boston, MA 02118. It will also be available online at [www.bphc.org/rfp](http://www.bphc.org/rfp). **The RFP will NOT be mailed to any applicants.**

**Tuesday, July 5, 2016**  
Letters of Intent Due by 12:00 noon

Letters of Intent to apply for Part A funds may be faxed to (857) 288-2194 to the attention of Eric Thai, Interim Director, HIV/AIDS Services Division. Letters can also be emailed to ethai@bphc.org. If the fax is not working or is busy, please call (617) 534-4559 to make other arrangements. A Letter of Intent form is provided in Section II of this RFP.

**Friday, July 22, 2016**  
Proposals due by 12:00 noon

Applications must be received by 12:00 PM (noon) on Friday, July 22, 2016. Mailed applications should be addressed to the attention of Eric Thai, Interim Director, HIV/AIDS Services Division, Boston Public Health Commission, 1010 Massachusetts Avenue, 2nd Floor, Boston, MA 02118. Hand-delivered applications may be dropped off at the BPHC reception desk at 1010 Massachusetts Avenue on the 2nd Floor. **THERE ARE NO EXCEPTIONS TO THIS DEADLINE.**

The responsibility for submitting a proposal to BPHC on or before the stated time and date, including the original (1) and fifteen (15) copies, will rest solely and strictly with the applicant. BPHC will in no way be responsible for delays in delivery caused by the United States Postal Service or caused by any other occurrence.

**July 22-30, 2016**  
Proposal Review/Evaluation Period

Review teams comprised of individuals from a variety of racial, cultural, and ethnic backgrounds will conduct an independent review of all eligible proposals. The pool of reviewers will be reflective of the HIV epidemic within the EMA. Reviewers will include a range of both consumers and professionals with expertise in HIV services.

**August - September 2016**  
Notification of Award

Letters will be mailed notifying applicants if their proposal will be funded or not. The contract period for FY 2016 Part A funds is March 1, 2016 to February 28, 2017, a 12-month period. Agencies funded under this RFP will have a six month contract (September 1, 2016 – February 28, 2017).
II. BACKGROUND INFORMATION

A. BOSTON EMA EPIDEMIOLOGICAL INFORMATION

One of the objectives of Part A is to deliver treatment and services to a client base that is reflective of the local epidemic, with a strong focus on populations that have historically been underserved. Please refer to the *HIV and AIDS Prevalence and Characteristics of PLWH Receiving Part A Services in 2014* tables in *Appendices B1-B2* when describing the populations for whom services will be provided.

B. PRINCIPLES AND STANDARDS

**National HIV/AIDS Strategy (NHAS)**

In 2010 the White House released the first NHAS. This comprehensive strategy has influenced the way HIV prevention and care services are prioritized, organized and provided across the country. The updated version of the national HIV/AIDS Strategy was signed by President Obama in July 2015. The updated version includes lessons learned and looks ahead to 2020 keeping the four primary goals:

1. reducing the number of new infections;
2. increasing access to care and optimizing health outcomes for PLWH;
3. reducing HIV-related health disparities, and health inequities;
4. Achieving a more coordinated national response to the HIV epidemic.

The NHAS Updated to 2020\(^1\) also highlights the need to pay particular attention to three priority activities:

- **Widespread HIV testing and linkage to care**, enabling PLWH to access treatment early.
- **Broad support for PLWH to remain engaged in comprehensive care**, including support for treatment adherence.
- **Universal viral suppression**, among PLWH, since it benefits their health and reduces transmission of the virus to others.

The NHAS recognizes the importance of early entrance into care for PLWH to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their status and to reduce stigma and discrimination against PLWH.

To the extent possible, program activities should strive to support the primary goals of the 2010 NHAS. As encouraged by the NHAS, programs should seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. Programs providing direct services should comply with federally-approved guidelines for HIV Prevention and Treatment (see [http://www.aidsinfo.nih.gov/Guidelines/Default.aspx](http://www.aidsinfo.nih.gov/Guidelines/Default.aspx) as a reliable source for current guidelines). For more information, see: [http://www.whitehouse.gov/administration/eop/onap/nhas](http://www.whitehouse.gov/administration/eop/onap/nhas).

**Ryan White Legislative Goals**

Additional elements stressed within the Ryan White legislation include:

**Improving Access for PLWH who know their status but who are not in care**: Service planning and

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delivery must address the needs of PLWH who know their status but are not in medical care.

**Improved Coordination & Linkage of Services:** Providers need to have formal relationships with a range of key points of entry into the system. These include:

- emergency rooms,
- substance abuse treatment programs,
- detoxification programs,
- adult and juvenile detentions facilities,
- STD clinics,
- federally qualified health centers,
- HIV disease counseling and testing sites,
- mental health programs, and
- homeless shelters.

Providers need to ensure that consumers have access to and *are maintained* in medical care.

**Development & Implementation of a Quality Management System**

- Funded programs must have a quality management system.
- Services should adhere to standards of care.
- Meaningful links must exist between health services and health-related support services.

**Minority AIDS Initiative (MAI)**

The Part A MAI originated in fiscal year (FY) 1999 when the 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.

After the original FY 1999 award of MAI funds, the Planning Council reviewed the MAI guidelines and recommended the Boston EMA utilize MAI funds to provide additional MCM and Psychosocial Support – Peer Support Services. Agencies funded in the MAI category must be minority-based agencies (board, staff and clients) and have a history of providing services to PLWH from disproportionately impacted minority communities.

**Early Identification of Individuals with HIV/AIDS (EIIHA)**

Early Identification of Individuals with HIV/AIDS (EIIHA) is the identifying, counseling, testing, informing, and referring of *diagnosed and undiagnosed* individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals to medical care.

The goals of this initiative are to: 1) increase the number of individuals who are aware of their HIV status, 2) increase the number of HIV positive individuals who are in medical care, 3) increase the number of HIV negative individuals referred to services that contribute to keeping them uninfected.

**Affordable Care Act (ACA)**

The ACA was signed into law in 2010.

“ACA creates new state-based health care coverage marketplaces, also known as exchanges, and a federally-facilitated health care coverage marketplace to offer millions of Americans access to affordable health insurance coverage. Under the ACA individuals with incomes between 100 to 400 percent of the
Federal Poverty Level (FPL) may be eligible to receive advance payments of premium tax credits and/or cost-sharing reductions to help pay for the cost of enrolling in qualified health insurance plans and for coverage of essential health benefits. In states that choose to expand Medicaid, non-disabled adults with incomes of up to 133 percent of FPL become eligible for the program, providing new coverage options for many individuals who were previously ineligible for Medicaid. In addition, the law requires health plans to cover certain recommended preventative services without cost-sharing, making health care more affordable and accessible for Americans.”

**HIV Care Continuum**

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.

**C. Planning Council Funding Principles**

Every year the Planning Council votes on a set of funding principles that guide the work of the Council, the Grantee, and the funded network of services. The funding principles have evolved over the years to better respond to the needs of PLWH and provide an accurate guide to the Grantee and services providers.

The current funding principles, as approved by the Planning Council on March 12, 2015 are listed below. (Note each of the principles listed below are of equal importance.)

- Services funded by Part A should provide for fair, equitable and just access for all persons with HIV throughout the EMA.
- Services should meet essential needs of consumers as defined by credible and timely data/needs assessments.
- Providers* funded by Part A should seek input from and/or participation by consumers as critical in reaching their decisions.
- Providers should be required to demonstrate optimal collaborations.
- Providers should be encouraged to seek out and maximize the use of all funding sources, rather than solely relying on Part A.
- Providers should demonstrate a commitment to prevent and mitigate stigma to the extent possible within their environments
- Providers must be able to demonstrate relevant, established ties to the affected populations they serve. Such ties may be shown through staffing, language/cultural competency, community involvement, and site of services.
- Providers must demonstrate a willingness to provide services to all affected populations and an ability to provide appropriate services to the populations they target.
- Providers should encourage and support self-advocacy among consumers.
- Providers should design programs tailored to the needs of the population served. To this end, staffing qualifications should not be needlessly inflated to exclude persons from affected populations, who have the requisite skills, from being employed in service delivery.
- Funding decisions should be made in such a way as to encourage the development/maintenance of high quality, user-friendly, innovative services.
• To ensure continuity of services, funding decisions should include a preference for organizations that provide services within the priority areas and demonstrate linguistic/cultural competency and appropriateness.

*In the context of Ryan White funding, a “provider” is defined as “a non-profit agency or public entity that is funded for one or more HIV service programs”.

D. Standards of Care

The Planning Council has established Standards of Care for all service categories. The Standards of Care were developed with input from Planning Council members, licensing agencies, other publicly funded programs, Part A and Part B Grantees, experts in specific service fields (both HIV-related and non HIV-related), and Ryan White-funded providers. Additionally, input and feedback from consumers throughout the EMA were also incorporated into the development of the Standards. The Standards of Care define a set of **minimum standards** of performance for service providers in each category, along with measures for these standards.

**Universal Standards of Care**

The Standards of Care are the minimum requirements that programs are expected to meet when providing HIV care and support services funded by Ryan White Parts A and B. The standards include the following program expectations:

• 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 PLWH in need of and eligible for services.
• The program is physically accessible to all PLWH.
• Staff is trained and capable of delivering services in a culturally and linguistically competent manner.

All applicants and contracted agencies are expected to meet these standards. Descriptions of service-specific Standards of Care for each category are described in latter sections of the document. Both Universal and Service Specific Standards of Care are available for viewing and can be downloaded or printed from the HIV/AIDS Services Division website at: [www.bphc.org/aids](http://www.bphc.org/aids).
III. DESCRIPTION OF FUNDED SERVICES

A. Medical Case Management Services

Possible FY 2016 available funds: $4,509,931 - $4,844,245
Possible MAI FY 2016 available funds: $682,004 - $732,559

The purpose of Ryan White Part A MCM services is to enable persons living with HIV who reside within the Boston EMA access to services that enhance access to care, support client engagement and retention in care, and support the health and well-being of clients living with HIV. The Health Resources and Services Administration (HRSA) Ryan White HIV Program defines Medical Case Management as: “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 MCM services. 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’s and other key family members’ needs and personal support systems.

Medical Case Management includes the providing treatment adherence counseling to ensure readiness for, and adherence to HIV treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of MCM including face-to-face, phone contact, and any other forms of communication.” Services must conform to the Planning Council definition and any relevant HRSA and BPHC policies.

HRSA Definition

Support for Medical Case Management Services (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication.

Activities that include at least the following:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Coordination of services required to implement the plan
- Continuous client monitoring to assess the efficacy of the plan
- Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary

Service components that may include:

A range of client-centered services that link clients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers’ Patient Assistance Programs, and other State or
local health care and supportive services)

- Coordination and follow up of medical treatments
- Ongoing assessment of the needs and support system for clients and key family members
- Adherence counseling to ensure readiness for, and adherence to, complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

**PLANNING COUNCIL DEFINITION**

A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are a component of MCM. 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. MCM includes providing treatment adherence counseling to ensure readiness for, and adherence to HIV treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of MCM, including face-to-face, telephone, and any other forms of communication.

The purpose of MAI MCM is to provide services that are culturally and linguistically appropriate to African Americans, individuals of African descent, Latinos, Native Americans, Asian Americans, Native Hawaiians, Pacific Islanders, and individuals of Asian descent who are living with HIV.

**Boston EMA Addendum:** Services must be offered in a variety of locations which may include one or more of the following venues: the agency or office setting, home visits, or other community-based settings.

**ELIGIBILITY**

For FY 2016, BPHC seeks applications from agencies or organizations that will demonstrate the ability to provide MCM services for PLWH within the Boston EMA. Applicants must ensure that proposed MCM service models are comprehensive and address client needs from outreach through discharge by brokering and coordinating clinical care and service delivery; monitoring access and engagement in care; and providing a range of supportive services that help clients build knowledge, develop skills, enhance emotional support, and generally promote health and wellness. MCM providers will be expected to adhere to the BPHC/MDPH Standards of Care for HIV Services which address specifics related to intake, assessment, service planning, and discharge. BPHC recognizes that MCM service models may differ depending on whether the service is offered in a clinical site and integrated with medical care providers, or whether it is offered in a community-based site. All MCM providers funded through this procurement will need to adhere to a minimum core set of expectations (explained below), several of which will necessitate a particular level of health literacy and involvement in medical care coordination and follow up. Services will be expected to meet the HRSA definition of Medical Case Management.

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2 The 2009 Standards of Care may be found at [www.bphc.org](http://www.bphc.org) and at [www.mass.gov/dph/aids](http://www.mass.gov/dph/aids). A process to begin updating the Standards of Care will begin following contract awards.
DESCRIPTION OF SERVICE COMPONENTS

The core MCM service components are listed and described below:

| A. Medical Care Coordination | Programs are required to directly provide services A-D. |
| B. Social Services Coordination |
| C. Adherence Support |
| D. Behavioral Health and Substance Abuse |
| E. Housing Search and Advocacy | Programs are required either to directly provide or coordinate access to Services E-G |
| F. Benefits Counseling |
| G. Outreach |

All applicants must demonstrate their capacity to provide directly in the community or via linkages the following MCM service components:

A. Medical Care Coordination

MCM services should be aligned with NHAS through facilitating access to care to help clients improve health outcomes, focusing on reduce HIV-related health disparities and health inequities as well as educating clients to help reduce new infections. 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.

Settings

Medical Case Management providers are expected to have the capacity to provide or coordinate access to MCM services in venues that are responsive to client needs. Whether an agency provides specific services (i.e. behavioral health, nutrition, substance abuse, etc.) directly or coordinates access to them all MCM providers are expected to provide MCM services in the following settings as needed:

1. Clinic-Based MCM services are provided in health centers, hospitals, clinics, physician practices, and other medical settings within an established HIV medical care infrastructure that has on-site or functional connections to other medical specialties, mental health services, and ancillary supports that clients may require. Clients may access services in a clinical setting because they find that the full integration of MCM services with their HIV care and treatment has the potential to meet their needs in a comprehensive and holistic manner. Individuals may also find that the “one-stop shopping” approach is also a practical and efficient way to access services.
2. Non-Clinical Based MCM services are provided in community-based organizations with expertise in HIV clinical care issues and the health care system. Clients must receive a sufficient level of care coordination to obtain medical, social, community, legal, financial, and other needed services. Clients may access MCM services in community-based settings for a variety of reasons, such as: the agency is uniquely equipped to provide culturally competent services to particular populations, or clients may live in areas that are geographically distant from their HIV medical care and prefer to access services closer to home.

3. Client Homes and Other Living Environments MCM services are provided in a non office based setting but not limited to residential settings (i.e. independent living environments congregate HIV or other supportive living environments). Clients may receive services in this setting relating to disease progression; acute period of illness; history of lapses in care; history of chronic homelessness or residential stability; episodes of social or medical fragility due to substance use or abuse, mental health; or lack of access to transportation.

4. Office-Based MCM services are provided in settings outside of the office that should include accompanied appointments (e.g., medical, social service, and financial/legal), as well as low-threshold engagements for clients who experience difficulties accessing services in Community-Based or Clinic-Based office settings.

B. Social Services Coordination

The focus of this service component is to help clients identify social service needs, help them access related resources, and support the successful utilization of these resources. Social Services Coordination may include, but is not limited to, assistance initiating phone calls to referral agencies; scheduling appointments; securing transportation; identifying food resources; brokering access to benefits counseling, housing search and advocacy, and peer support (if not provided by the MCM team); communicating with other agencies 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.

Implementation of this service component involves more than the brokering of service delivery by other providers; MCM providers must have the capacity to recognize the challenges and barriers that clients face in managing the coordination of services on their own and must have the skills to help clients develop strategies to address these issues and successfully navigate the service system. This often requires extensive knowledge and expertise, particularly related to mental health, substance use or abuse, stigma, and trauma. Though MCM providers are not expected to provide therapeutic support in these areas, agencies must ensure that staff have the adequate educational background and ongoing training and support to recognize symptoms and behaviors that may be connected to these issues and that may need to be addressed not only by means of supported referrals, but by the methods with which MCM services are delivered, e.g., through Motivational Interviewing\(^3\) and other techniques or frameworks.

MCM providers are expected to engage in discussions with clients regarding HIV status disclosure to partners. MCM programs must be familiar with HIV Partner Services (HIV PS) which is a set of voluntary services that assists PLWH to identify their sexual and drug injection partners, notify these

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partners of past or ongoing exposure to HIV, facilitate partners’ access to HIV testing services, and actively support HIV infected partners’ entry into care (see Appendix G). HIV PS providers discuss the importance of partner notification with clients and provide information about a range of notification options. HIV PS providers also help interested clients access MDPH Disease Intervention Specialists (DIS). MCM providers are expected to inform all clients about the availability of PS and to provide clients who choose to participate with documented, supported referrals to HIV PS providers in the region.

To coordinate seamless care, MCM providers are expected to establish formalized referral relationships and linkage agreements with specified points of entry. MCM providers should have a communication system that includes explicit release of information protocols and documentation of client authorization for release of information, and should clearly determine respective roles and responsibilities within the coordinated service delivery model. Memoranda of Agreement should be established, updated as necessary, and maintained on file at each agency.

C. Treatment Adherence

Adherence Support is the provision of support, strategies, counseling, and/or special programs to 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. In the context of this procurement, the service is intended to be a non-reimbursable service that complements the information and advice offered by the medical care provider. Adherence Support may include, but is not limited to, the implementation of regular 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 a range of adherence strategies and options 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. When appropriate programs may wish to use a Directly Observed Therapy (DOT) model to help newly diagnosed or non-adherent clients adapt engage or re-engage in care. Program staff will also be expected to recognize when referrals to mental health counseling and treatment may be appropriate, and when clients should be redirected to their medical care providers.

D. Behavioral Health and Substance Abuse

Comprehensive services for PLWH must include information, 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. Resources that are culturally appropriate and consistent with the client’s literacy level and language capacity must be available. Discussions should be client-centered, rooted in a harm reduction


5 Any educational materials distributed to clients through MDPH and BPHC-funded HIV/AIDS MCM programs must be reviewed and approved consistent the Office of HIV/AIDS and HIV/AIDS Services Division Materials Review process.
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 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.

MCM providers must be comfortable talking with clients and their partners about HIV, STD, and viral hepatitis transmission, using tools and supplies to demonstrate proper use, and must have the skills to work with clients on strategies to reduce the risk of disease transmission. MCM staff must be able to talk explicitly about substance use and abuse, and drug injection behaviors; be familiar with risk reduction tools including external (male) and internal (female) condoms, sterile injection equipment, and bleach kits; and have the ability to 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). Staff must also have a basic understanding of mother-to-child (vertical) HIV transmission risk and risk reduction options and must have the capacity to make supported referrals to HIV/Obstetrics and Gynecology (OBGYN) care providers for pregnant clients or for clients who are considering pregnancy.

E. 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. MCM services described in this procurement are consistent with objectives recently articulated by the United States Interagency Council on Homelessness which include integrating health care services with homeless assistance programs and housing.6

In recognition of the connection between housing stability and health outcomes, MCM 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. Based on this information, staff must either provide the client with Housing Search and Advocacy services directly or via an established coordination mechanism with a Housing Search and Advocacy provider.

F. Benefits Counseling

MCM 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 Benefits

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Counseling service directly or via an established coordination mechanism 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 MCM teams, including through outposting, by means of Memoranda of Agreement.

All MCM providers must have documentation of each client’s insurance status and must document proof of insurance at least once every six months. Insurance coverage options include: MassHealth (Medicaid), ConnectorCare, Medicare/Medicare Part D, Employer Subsidized, Veteran’s Affairs, Private non-groups (qualified health plans via the MA or NH Health Connectors), Health Safety Net Private, and MIC (Mass Insurance Connection). Insurance can be verified through HDAP approval letter, letter from insurer, premium statement, dated print out from the exchange, Mass Health approval letter and Electronic Medical Record print out. If a client is not eligible for any existing insurance plans, then the provider should document the reason and how the client will access medical services and prescriptions.

G. Outreach

MCM program providers must include an outreach component. HRSA defines outreach as efforts 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. Outreach services do not include HIV counseling and testing, or HIV prevention education. However, outreach efforts should coordinate with those sites offering HIV Prevention, Screening, and Referral Services to help link newly identified PLWH to care. Outreach in the community should also extend to PLWH lost to care and be available for clients who require additional support, such as directly observed therapy and other services.

ACUITY OF SERVICES

BPHC recognizes that clients have varying levels of MCM needs and that these needs may shift over time. BPHC is interested in supporting a service system that is responsive, flexible, and efficient in tailoring services to individual client needs. As such, applicants are asked to articulate a strategy to tailor services relative to demonstrated need. This model should allow for more frequent, time-intensive, and specialized service engagements for clients with multiple needs initially identified. It must also be able to serve clients with short-term, intermittent, or low levels of need. Needs must be monitored and intensity of services adjusted to ensure clients reach and maintain viral suppression. Different levels of service may provide clients access to personnel with varying levels of skills and qualifications.

All MCM services delivered through this procurement must include mechanisms to provide client intake, assessment, care/service planning, reassessment, and discharge planning. MCM providers are expected to conduct comprehensive assessments to determine health status, clinical and social service needs, and client priorities. Agencies will be asked to describe how these assessments and
reassessments will inform service delivery. As per HRSA’s guidance, reassessments must take place every six months. All agencies must describe all requirements related to accessing MCM services to clients, including the reassessment requirement, so they are fully informed before deciding whether to participate in MCM services. Clients who decline MCM services should be advised that they may elect to access such services in the future. Agencies should inform clients who do not opt for MCM that other Health-Related Support Services may be available.7

Applicants are encouraged to describe service models that specify time-limited MCM interventions that promote shifts to lower levels of intensity and, ultimately discharge, following the accomplishment of health-related goals, including demonstrated achievement and maintenance of viral suppression. BPHC understands that there will be subset of clients for whom ongoing, intensive MCM will be necessary. However, it is expected that the majority of clients will need MCM services for a defined period of time, during significant periods of need. Shifts to lower intensity service provision and discharge planning efforts must be constructed and implemented in ways that promote and support client success in anticipated self-sufficiency.

Examples of situations in which a high level of MCM service may be appropriate include (but are not limited to): an AIDS diagnosis; initiation of second- or third line antiretroviral medicine; engagement in DOT; active substance use or early recovery; recent discharge from detoxification services; lack of health insurance; homelessness; recent incarceration; complex adherence challenges; untreated and/or complex mental illness; trauma; new HIV diagnosis; hepatitis C co-infection; immigration issues; domestic violence; very low income; pregnancy; or parenting needs. Clients may also be engaged in high intensity services based on health, financial, legal, or social service crises including (but not limited to) loss of income, eviction, sudden change in health status, or relapse.

Clients accessing the less intensive levels of service may demonstrate a particular level of self-management capacity that enables them to manage their medical, behavioral health, and social service needs. These clients might need short-term or episodic MCM assistance and may express a desire to stay connected to MCM services without intensive, frequent contact with staff. Clients accessing this level of service are not expected to need as frequent or detailed contacts as clients accessing a higher level of service but must, at a minimum, adhere to the six-month reassessment requirement. This reassessment may be conducted by telephone or in person.

**STAFFING EXPECTATIONS**

**A. 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 proposing to directly offer services in client homes and other living environments should include team members who can provide these services. Applicants must submit job descriptions for the roles that will comprise their MCM teams.

In recognition of the value of peer support as a service that helps improve health and wellness, BPHC intends to expand and enhance the peer leader role by promoting the inclusion of peer leaders into MCM

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7 Clients who want to access Rental Assistance and Medical Transportation services must be enrolled in a BPHC or MDPH-funded HIV/AIDS MCM program.
multidisciplinary teams. During the course of the MCM service engagement, peer leaders may help with the implementation of any service component, as described above. For example, peer leaders may orient clients to the service system; provide basic HIV, STI, and viral hepatitis information; help develop risk reduction plans; help clients prepare for medical appointments, accompany clients to appointments and/or assist with follow-up; help complete benefits/housing/health insurance applications; provide non-medical adherence support; help with the implementation of the care/service plan; and offer support around substance abuse and risk reduction; facilitate focus groups; support managing side effects of meds and offer emotional support. Through an outreach or other direct care role, peer leaders can also help re-engage and support clients who need assistance maintaining ongoing engagement in care.

Description of Peer Support is described in latter sections of application.

Applicants for a MCM model that incorporates peer leaders must articulate a commitment to fully integrate peer leaders into their systems of care and staff structures. These applicants must describe structured, high-functioning systems of hiring, orientation, supervision, and training and must offer peer leaders compensation as either full-time or part-time agency staff. Funded agencies will be expected to adhere to the Guidelines for Peer Support Programs jointly established by BPHC and MDPH available at www.bphc.org and www.mass.gov/dph/aids. Applicants that do not integrate peer leaders into their MCM teams must have referral mechanisms with agencies that offer peer support services.

B. 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. In addition to the expectations outlined below and the competencies specified in the BPHC/MDPH Standards of Care for HIV Services, additional requirements are addressed in Section 8 “Contract Requirements.”

MCM service providers must demonstrate many common areas of knowledge and skill, but the extent and nature of expertise may vary according to the setting. For example, agencies offering the Clinic-Based service 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.

Agencies directly providing the benefits counseling service 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. Agencies 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.

MCM administrative and clinical supervisors must actively maintain an understanding of BPHC requirements in order to fully support staff members who are providing direct services to clients. Administrative supervisors must ensure that the staff they oversee, including peer leaders, 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 MCM Core Competency Trainings administered by BPHC’s MCM Training and Capacity Building program.

**REQUIRED SUBSERVICE REPORTING FOR E2BOSTON**

The following service codes will be reported to BPHC for Medical Case Management:

<table>
<thead>
<tr>
<th>Subservice</th>
<th>Service Unit Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Intake, Started</td>
<td>Unit Based</td>
<td>Enter one (1) when initial intake begins.</td>
</tr>
<tr>
<td>Assessment, Completed</td>
<td>Unit Based</td>
<td>Enter one (1) when assessment is completed.</td>
</tr>
<tr>
<td>Visit, General</td>
<td>Time Based</td>
<td>A face-to-face session between provider and client where MCM services are provided. One Unit = One Hour.</td>
</tr>
<tr>
<td>Visit, Home-Based</td>
<td>Time Based</td>
<td>A face-to-face session between provider and client where MCM services are provided in a non-office based setting, including but not limited to residential settings (i.e., independent living environment, congregate HIV or other supportive residential programs).</td>
</tr>
<tr>
<td>Phone, Follow-up</td>
<td>Time Based</td>
<td>Enter one (1) for each non-initial telephone encounter which provides client-centered assistance. One Unit = One Phone Call.</td>
</tr>
<tr>
<td>Reassessment/Follow-up Service Plan, Completed</td>
<td>Unit Based</td>
<td>Enter one (1) when reassessment/follow-up service plan is completed.</td>
</tr>
<tr>
<td>Supported Referral</td>
<td>Unit Based</td>
<td>Enter one (1) for each active process of facilitating a client’s access to HIV Support Services and any other services necessary to reduce barriers to care.</td>
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</tbody>
</table>

**SERVICE SPECIFIC STANDARDS OF CARE**

The Service Specific Standards of Care are the requirements that programs are expected to meet when providing support services funded by Ryan White Parts A and B. The MCM service specific standards include the following program expectations:

- File exists for at least 25 active clients for each 1.0 FTE case manager; written justification on file if case manager has less than 25 active clients
- Documentation of a file review by a MCM supervisor every six months
- Newly hired case managers meet the minimum qualifications; job description and resumes filed
- Documentation that staff have completed funder training(s) within 3 months of hire
- Comprehensive initial assessment is completed within 30 days of initial intake and completed assessment form exists in each client file
- A completed and signed individual service plan/client action plan is in each client file
- Each active client is reassessed every 6 months and documentation of reassessment is in each client file; at least once per year reassessment is conducted in person
**Service Category Guidelines**

The following guidelines apply to MCM and MAI MCM programs. **All guidelines should be addressed within the proposal application.**

- All funded programs shall provide written assurances and maintain documentation showing that MCM services are provided by trained professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team.
- All funded programs shall maintain client records that include the required elements for compliance with contractual and Ryan White programmatic requirements, including required MCM activities such as services and activities, the type of contact, and the duration and frequency of the encounter.
- If home and community based services are provided as part of MCM services, the funded programs shall:
  - Ensure that written care plans with appropriate content and signatures are consistently prepared, included in client files, and updated as needed.
  - Establish and maintain a program and client recordkeeping system to document the types of home services provided, dates provided, the location of the service, and the signature of the case manager or the clinical health care professional who provided the service at each visit.
- All programs shall make available to BPHC program records and client files as required for monitoring.
- All funded programs shall provide assurance that the services are provided in accordance with allowable modalities and locations under the definition of MCM services.
- All funded programs shall maintain, and make available to the grantee on request, copies of appropriate licenses and certifications for professionals providing services.
- When supported referrals for health care/support services are made, the funded program shall:
  - Maintain program files that document:
    - Number and types of referrals provided
    - Benefits counseling and referral activities
    - Number of clients served
    - Follow up provided
  - Maintain client records that include required elements as detailed by BPHC, including:
    - Date of service
    - Type of communication
    - Type of referral
    - Benefits counseling/referral provided
    - Follow up provided
  - Maintain documentation demonstrating that services and circumstances of referral services meet contract requirements.
**ADDITIONAL MAI MEDICAL CASE MANAGEMENT REQUIREMENTS**

The Subcontractor shall establish and maintain a system that tracks and reports additional information for the following for MAI services:

- Dollars expended
- Number of clients served
- Units of service overall and by race and ethnicity, women, infants, children, youth
- Client-level outcomes

- The Subcontractor shall maintain a system to track and report MAI expenditures, the number and demographics of clients served, and the outcomes achieved. The Subcontractor shall provide timely data to the grantee/BPHC for use in preparing the Annual Report.

- The Subcontractor shall maintain client-level data on each client served, including in each client record demographic status, HIV clinical information, HIV-care medical and support services received, and the client’s Unique Client Identifier.

**OTHER SERVICE REQUIREMENTS**

- All funded programs shall maintain appropriate relationships with key points of entry by establishing written referral formats and linkage agreements between partners, and documenting referrals at each entry and linkage point.
- All funded programs shall maintain file documenting agency activities for the promotion of HIV services to low-income individuals (not to exceed 500% FPL), including copies of HIV program materials promoting services and explaining eligibility requirements.
- All funded programs shall inform BPHC of any expected under-expenditures as soon as identified.
- All funded programs shall maintain on file documentation of Medicaid Status certifying that they are able to receive Medicaid payments.
- All funded programs shall document efforts and timeline for certification if in process of obtaining this certification.
- All funded programs shall maintain client-level data on each client served via BPHC’s e2Boston, including in each client record demographic status, HIV clinical information, HIV-care medical and support services received, and the client’s Unique Client Identifier.
- All funded programs shall submit this report online as an electronic file upload according to BPHC guidelines.
- All funded providers must participate in the EMA Quality Management program.
- All funded program must comply with the BPHC HIV/AIDS Services Division (HASD) Financial Eligibility policy.
B. PSYCHOSOCIAL SUPPORT-PEER SUPPORT SERVICES
Possible FY 2016 available funds: $776,095 - $833,626
Possible MAI FY 2016 available funds: $115,130 - $123,664

The purpose of Ryan White Part A Peer Support services is to enable persons living with HIV who reside within the Boston EMA access to support services provided by and for PLWH that enable them to empower themselves and develop effective strategies for living healthy lives. Services must conform to the Planning Council definition and any relevant HRSA and BPHC policies.

HRSA DEFINITION
Support for Psychosocial Support Services that may include: support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care/counseling, caregiver support, bereavement counseling, and Nutrition counseling provided by a nonregistered dietitian. Note: Funds under this service category may not be used to provide nutritional supplements.

Pastoral care/counseling supported under this service category to be: provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider); provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available; and available to all individuals eligible to receive Ryan White services, regardless of their religious denominational affiliation.

PLANNING COUNCIL DEFINITION
Support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. They include nutrition counseling provided by a non-registered dietitian, but exclude the provision of nutritional supplements.

The purpose of MAI psychosocial support is to provide services that are culturally and linguistically appropriate to African Americans, individuals of African descent, Latinos, Native Americans, Asian Americans, Native Hawaiians, Pacific Islanders, and individuals of Asian descent living with HIV.

Boston EMA Addendum: Services funded under this category include peer support, where the person providing the psychosocial support is a PLWH and of the client’s self-identified community.

ELIGIBILITY
For FY 2016, BPHC seeks applications from agencies or organizations that will demonstrate the ability to provide Psychosocial Support- Peer Support services for PLWH within the Boston EMA. Applicants may propose to integrate peer support services into MCM models or may propose freestanding Peer Support service models. Applicants for MCM are encouraged to consider when integrating peer support services would the service benefit client health and well-being, improve service quality and responsiveness, and address gaps in regional service provision. Applicants proposing freestanding Peer Support service models must ensure that they have collaborative relationships with organizations that provide MCM.
DESCRIPTION OF SERVICES

All applicants must demonstrate their capacity to provide the following services of a Psychosocial Support (Peer Support) program:

Individual-Level Peer Support

Individual-Level Peer Support in which peer leaders offer information, emotional support, and practical guidance to PLWH in homes, drop-in centers, substance abuse or mental health treatment programs, multiservice centers, non-traditional venues, and/or other settings. Models must include in-person visits and applicants may also propose to include additional methods of client contact, such as Internet-based and telephone-based services. Internet and telephone-based services must be provided by peer leaders as part of a peer support program that includes in-person services.

Group-Level Peer Support

Group-Level Peer Support involves PLWH coming together to share common experiences and challenges of living with HIV, exchange information, and provide emotional and practical support. Program models may incorporate the participation of partners, caregivers, and family members of PLWH.

BPHC intends to fund two main sub-categories of group-level peer support: Traditional Support Groups and Educational Support Groups. In addition, BPHC may fund a subset of individual-level and/or group-level peer support providers for Peer Networking.

REQUIRED SUBSERVICE REPORTING FOR E2BOSTON

The following service codes will be reported to BPHC for the Psychosocial Support (Peer Support):

<table>
<thead>
<tr>
<th>Subservice</th>
<th>Service Unit Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Support Session, Group</td>
<td>Time Based</td>
<td>A regularly scheduled meeting for three or more people with HIV and facilitated by someone who is HIV infected. One Group Unit = One Hour.‡</td>
</tr>
<tr>
<td>Peer Support Session, Individual</td>
<td>Time Based</td>
<td>Any face-to-face encounter between an HIV infected peer advocate and client where peer support services are provided. One Unit = One Hour.</td>
</tr>
<tr>
<td>Peer Networking Peer Support Session</td>
<td>Unit Based</td>
<td>A regularly scheduled meeting session for three or more people with HIV where participants are provided with a range of activities that reinforce their social network and psychosocial support.</td>
</tr>
</tbody>
</table>

SERVICE SPECIFIC STANDARDS OF CARE

The Service Specific Standards of Care are the requirements that programs are expected to meet when providing support services funded by Ryan White Parts A and B. The Peer Support service specific standards include the following program expectations:

- One-on-one peer support services are provided by PLWH
- Peer support groups are facilitated/co-facilitated by PLWH
• Provision of one-on-one peer support services is documented in each client file, including date, duration, and general topics covered
• Documentation of support groups on file; support groups attendance documentation in client file
• Signed documentation on file indicating dates of one-on-one and/or group supervision, type of supervision (clinical/administrative), and name of supervisor

SERVICE CATEGORY GUIDELINES
The following guidelines apply to Psychosocial Support- Peer Support and MAI Psychosocial Support- Peer Support programs. All guidelines should be addressed within the proposal application.

• All programs must ensure that Ryan White funds will be utilized as the payer of last resort.
• All funded programs shall maintain program records that document:
  • Types and level of activities provided
  • Client eligibility

• All funded programs shall maintain documentation demonstrating that:
  • Funds are used only for allowable services
  • No funds are used for provision of nutritional supplements
  • Any pastoral care/counseling services meet all stated requirements

• All programs must ensure that clients are linked to a MCM program that will coordinate their full range of care.
• All programs must have the capacity to collect and submit client level data.
• All funded providers must participate in the EMA Quality Management program.
• All funded program must comply with the BPHC HIV/AIDS Services Division (HASD) and the Massachusetts Department of Public Health (MDPH) Office of HIV/AIDS (OHA) Financial Eligibility policy.

ADDITIONAL MAI PSYCHOSOCIAL SUPPORT (PEER SUPPORT) REQUIREMENTS

• All MAI funded programs shall establish and maintain a system that tracks and reports additional information for the following for MAI services:
  • Dollars expended
  • Number of clients served
  • Units of service overall and by race and ethnicity, women, infants, children, youth
  • Client-level outcomes

• All MAI funded programs must maintain a system to track and report MAI expenditures, the number and demographics of clients served, and the outcomes achieved
• All MAI funded programs must provide timely data to BPHC for use in preparing the Annual Report
C. MEDICAL TRANSPORTATION SERVICES
Possible FY 2016 available funds: $255,588 - $274,534

The purpose of Ryan White Part A medical transportation services is to enable PLWH who reside within the Boston EMA access medical and health related support service appointments. Services must conform to the Planning Council definition and any relevant HRSA and BPHC policies.

**HRSA Definition**

Medical Transportation Services that enable an eligible individual to access HIV-related health and support services, including services needed to maintain the client in HIV medical care, through either direct transportation services or vouchers or tokens. May be provided through: contracts with providers of transportation services; voucher or token systems; use of volunteer drivers (through programs with insurance and other liability issues specifically addressed); purchase or lease of organizational vehicles for client transportation programs, provided the BPHC receives prior approval for the purchase of a vehicle.

**Planning Council Definition**

Services funded under this category include, but are not limited to conveyance services provided, directly or through a voucher, to a client to enable him or her to access health care services. Such services include taxi vouchers and public (subway or bus passes) and private transport services.

**Eligibility**

For FY 2016, BPHC seeks applications from agencies or organizations that will demonstrate the ability to provide medical transportation services for PLWH within the Boston EMA. Applicants must ensure that Medical Transportation service planning will 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, agencies may offer transportation services directly in the form of bus/subway/train/other fares or taxi fares (paid directly to the taxi company).

**Description of Services**

All applicants must demonstrate their capacity to provide the following services of a medical transportation program:

<table>
<thead>
<tr>
<th>Subservice</th>
<th>Service Unit Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-way Ride, Public</td>
<td>Unit Based</td>
<td>One-way transportation by public transport system (subway or bus passes) for client to access healthcare or support services.</td>
</tr>
<tr>
<td>One-way Ride, Taxi/Transportation Company</td>
<td>Unit Based</td>
<td>One-way transportation by taxi or other similar company for client to access healthcare or support services.</td>
</tr>
</tbody>
</table>
**Service Specific Standards of Care**

The Service Standards of Care are the requirements that programs are expected to meet when providing support services funded by Ryan White Parts A and B. The Medical Transportation service specific standards include the following program expectations:

- Documentation of Medicaid status for programs serving children.
- Program provides accessible transportation to individuals with disabilities.
- Emergency protocol for health and safety incidents is reviewed with staff and posted in the agency.
- Copies of registrations and insurance coverage on file for private transportation vehicles.
- Signed and dated form on file that outlines volunteer responsibilities.
- Program has written accident policy on file; policy reviewed and signed by private transportation operators.

**Service Category Guidelines**

The following guidelines apply to Medical Transportation programs. **All guidelines should be addressed within the proposal application.**

- All programs must ensure that Ryan White funds will be utilized as the payer of last resort.
- All funded programs shall maintain program records that document:
  - The level of services/number of trips provided.
  - The reason for each trip and its relation to accessing health and support services.
  - Trip origin and destination.
  - Client eligibility.
  - The cost per trip.
  - The method used to meet the transportation need.
- All funded programs shall maintain documentation showing that they are meeting stated contract requirements with regard to methods of providing transportation:
  - Reimbursement methods do not involve cash payments to service recipients
  - Mileage reimbursement does not exceed the federal reimbursement rate
  - Use of volunteer drivers appropriately addresses insurance and other liability issues
- All programs must ensure collection and maintenance of data and shall document that funds are used only for transportation designed to help eligible individuals remain in medical care by enabling them to access medical and support services
- All funded providers shall obtain BPHC approval prior to purchasing or leasing a vehicle(s)
- All programs must have the capacity to collect and submit client level data.
- All funded providers must participate in the EMA Quality Management program.
- All funded program must comply with the BPHC HIV/AIDS Services Division (HASD) Financial Eligibility policy.
### IV. PROPOSAL REVIEW AND SELECTION

#### A. SUBMISSION PROCESS

The proposal and all legal documentation must be received by **12:00 noon on Friday, January 15, 2016** at BPHC’s, HIV/AIDS Services Division reception desk on the 2nd Floor. The proposal package should be addressed to the attention of:

**Eric Thai, Interim Director**  
HIV/AIDS Services Division  
Boston Public Health Commission  
1010 Massachusetts Avenue, 2nd Floor  
Boston, Massachusetts 02118

THERE WILL BE NO EXCEPTIONS TO THE NOON DEADLINE. Proposals will be time stamped in order to ensure proper receipt.

The responsibility for submitting a complete proposal, including the original (1) and fifteen (15) copies, to BPHC on or before the stated time and date will rest solely and strictly with the applicant. BPHC will in no way be responsible for delays in delivery caused by the U.S. Postal Service or caused by any other occurrence.

**Collaborative Proposals**

BPHC strongly encourages organizations to submit joint applications for services. Such proposals should emphasize shared resources and services coordinated between agencies to capture the special expertise of each partner. The goal is achievement and maintenance of viral suppression through a seamless system of care. The lead agency must be identified in the collaborative proposal and a representative of the lead organization must sign the cover page of the application and submit a comprehensive abstract. The proposal must specify which organization will act as the fiscal agent. If there are differences in the target dates for implementation of the service to be 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. This documentation should be submitted as an attachment. BPHC reserves the right to verify the arrangements through inspection of supporting documents.

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

#### B. REVIEW AND SELECTION PROCESS

All proposals will be reviewed using an external, objective review process. A committee including community representatives, consumers, professionals, and members of the Boston EMA HIV Services Planning Council will review proposals and make recommendations for funding. During the proposal 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 upon the evaluation criteria (**Section II**). Scores assigned by reviewers will affect recommendation for funding and the level of an applicant’s grant award. Individual
applications are not compared to other applications; rather, each is evaluated independently in terms of its responsiveness to application questions.

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

- negotiate an applicant's Scope of Services,
- require an applicant to make appropriate linkages with other agencies and programs accepted under this RFP,
- negotiate award amounts, and
- fund with conditions of award.
V. CONTRACT REQUIREMENTS

All funded agencies must sign a contract with BPHC to receive funding. The contract will include, but not be limited to, provisions related to the following:

A. 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), status of funded agencies 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.

B. HIPAA

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

C. REPORTING

Thorough program reporting and monitoring are essential to evaluate and measure how effectively Ryan White funds are utilized to fulfill the unmet service needs of PLWH. HRSA also considers this information when allocating Ryan White funds to the EMA. Failure to produce timely and adequate reports will jeopardize the agency'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, an agency agrees to adhere to the following if funded:

Annual Provider WorkPlan Submission

All funded agencies will be required to submit an annual provider WorkPlan. The WorkPlan will help funded agencies create evidence-driven and performance-based targets at the start of each fiscal year. A WorkPlan shall address:

- the agency’s plan/vision;
- any agency and/or program successes and challenges;
- the structure of the agency’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.

Client-Level Data Submission

All required data are considered a program deliverable. Invoices will not be processed for payment if required data have not been received. Funded providers will be required to submit client-level
demographic and utilization data on a quarterly basis and client-level outcome measurement data on a semi-annual basis. All agencies funded by BPHC will use the e2Boston data entry system to track client utilization and services, as well as for mandatory report submission. Agencies can manually enter data into the system at regular intervals or develop a data import process for higher volume agencies. e2Boston acts as a one step portal where funded agencies can satisfy HRSA reporting requirements (such as the RSR) as well as track client utilizations, demographic info, and health outcomes. The system gives agencies the ability to track volume of services and outcomes over time. Agencies are expected to review data including (but not limited to) HIV viral loads to ensure that the goal of viral suppression in clients is being reached.

Quarterly Narrative Submission

All funded agencies will be required to submit, in written quarterly narratives. These reports should reflect program specifics as negotiated in the Scope of Services. Such reports shall address:

- the unduplicated number of clients including demographic characteristics, transmission category, and stage of HIV-related illness;
- number of service units provided during the quarter;
- progress made and efforts undertaken to meet goals and objectives for each funded service;
- any problems, obstacles or challenges; and
- any actions taken or plans to resolve such problems, obstacles, or challenges in meeting the projected or targeted goal of the contract.

With the introduction of e2Boston, all Scope targets will be stored in the data base. Providers will be able to run reports that include scope targets for side by side comparison when extracting data for quarterly reports.

- Client demographics Table will be replaced by reports generated in e2Boston. Instead of filling out a Client Demographics Table template, a provider can print the appropriate report from e2Boston. A provider can select the service category for the program that the quarterly report references and then input a time frame to collect appropriate data.

- Data elements that a provider may choose to include in a quarterly report can also be accessed as tables in e2Boston. Tables can be created based on clients’ age, housing status, gender, and or other identifying factors.

Client Outcome Reports

Outcomes must be written in e2Boston. Providers will be instructed on how to produce specific reports in e2 Boston.

Client level outcome reports capture health and quality of life outcomes for PLWH. Some of these indicators are required by HRSA. All funded agencies will be required to provide the following information in e2Boston:

1. Sources of client-level information indicate

2. Laboratory Results/Measures
   a. CD4 count
   b. Viral load
   c. Primary medical care engagement
   d. Medical Case Management status
3. Health and Quality of Life Measures:
   a. Adherence to HIV medication
   b. Side effects of HIV medication
   c. Mental health status
   d. Access to support network
   e. Care adherence
   f. Housing status

Outcome reports will be due on a rolling basis. Successful applicants will be provided with detailed instructions.

_Fiscal Submission_
All funded agencies will be required to submit monthly invoices detailing the allowable costs during the previous calendar month (see Attachment 2). Such invoices must include copies of supporting documentation that verify such costs.

_D. MONITORING_

_Required Reporting to HRSA_
All funded providers will be required to collect all data necessary to complete any required reporting as mandated by HRSA, for example, The Ryan White HIV Program Services Report (RSR).

_Site Visit(s)_
Each funded agency shall participate in no less than one (1) site visit per calendar year. Site visits include a review of both fiscal and programmatic issues. Key personnel involved in 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 provides technical assistance to recipients of Ryan White funds regarding reporting and monitoring requirements as well as programmatic concerns as necessary.

_Other_
BPHC may request additional information at any time. BPHC may provide specific formats for submitting reports that the funded agency will be required to follow.

_E. RYAN WHITE PROGRAM ASSURANCES_

The following assurances will be required of subcontractors:
- 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.
To make its services available to any eligible individual without regard to ability to pay or the current or past health condition of the individual and to make its services available in settings accessible to low-income persons.

To ensure client eligibility for services funded by Ryan White Part A dollars by following the HIV Verification guidelines.

To ensure client confidentiality by obtaining client consent for the visual review of files and make clients aware of HIPAA Business Partner status with BPHC. To participate in the needs assessment process.

To participate in any evaluation conducted by and/or for BPHC or the funding source related to the dissemination and/or utilization of Ryan White Part A funds.

To comply with monthly, quarterly, and annual reporting requirements.

To attend mandatory meetings with other Part A Ryan White funded service providers for the purpose of training, networking, exchanging information, sharing resources, and formalizing linkages.

To comply with all other requirements as stipulated in the RFP.

F. RECORD MAINTENANCE

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

G. CONTRACT PAYMENTS

BPHC will reimburse funded providers for allowable expenses, within 30 days of receipt, after review and approval of invoices and appropriate supporting documentation, including required data. For newly funded agencies, one quarter of the award may be paid upon execution of the contract for the FY 2014 services included in this RFP (see Attachment 2).

H. SCOPE OF SERVICES AND BUDGET

Funded providers negotiate a contract with BPHC, which includes a Scope of Services that specifies the service to be provided, the expected number and demographic composition of clients to be served, the expected number of service units to be delivered, the price per unit (when applicable), and an approved budget which contains personnel and programmatic line items for cost reimbursement contracts or units of service for unit rate contracts. Providers are expected to meet the goals and objectives set in the Scope of Services and are limited to expend resources according to the budget. Failure of a selected applicant to satisfactorily negotiate a contract within a reasonable time may result in the applicant forfeiting its award.

I. CONTRACT AMENDMENTS

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

J. CONTRACT EXTENSIONS/RENEWALS

Funded service providers with programs that are not up for bid may receive a contract extension/renewal for future fiscal years. This renewal is subject to 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.
VI. FISCAL CONDITIONS AND FUNDING RESTRICTIONS

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

FUNDING RESTRICTIONS

The following restrictions have been mandated by HRSA:

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. Recipients of grant funds must promote families and communities’ understanding of the new health care coverage options under the ACA and provide eligible individuals assistance to secure and retain coverage. About the ACA:

The Affordable Care Act was signed into law in 2010. “ACA creates new state-based health care coverage marketplaces, also known as exchanges, and a federally-facilitated health care coverage marketplace to offer millions of Americans access to affordable health insurance coverage. Under the ACA individuals with incomes between 100 to 400 percent of the Federal Poverty Level (FPL) may be eligible to receive advance payments of premium tax credits and/or cost-sharing reductions to help pay for the cost of enrolling in qualified health insurance plans and for coverage of essential health benefits. In states that choose to expand Medicaid, non-disabled adults with incomes of up to 133 percent of FPL become eligible for the program, providing new coverage options for many individuals who were previously ineligible for Medicaid. In addition, the law requires health plans to cover certain recommended preventative services without cost-sharing, making health care more affordable and accessible for Americans.”

6. 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 (without regard to whether any of these subcontractors expend more or less than 10 percent for such expenses). For the purposes of the 10% aggregate cost cap, administrative activities include:

   a. Usual and recognized overhead activities, including rent, utilities, and facility costs.
   b. 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.

7. 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 subcontractor 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.

8. 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 PLWH. Applicants are reminded that Part A Grantees/Sub-Grantees are subject to
audit on this and other restrictions on use of funds.

9. 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

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

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.

10. 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, which can be found on the BPHC and HRSA
websites, as well as the BPHC Providers’ Manual.

11. All travel must be local (within the EMA) and directly related to the services provided under the
specific contract.
VII. MISCELLANEOUS

A. 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 Grantees, HRSA, CDC, MDPH, NH DHHS, and other entities to ensure that services and activities funded under this procurements are coordinated and does not duplicate or supplant other funding streams that applicant agencies may already receive. Agencies 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.

B. 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 EMA to take such action. Notice of the cancellation will be made to applicants or potential applicants, as appropriate.

C. 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.

D. 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 within thirty (30) days of the notification of award to:

Eric Thai, Interim Director
HIV/AIDS Services Division
Boston Public Health Commission
1010 Massachusetts Avenue, 2nd Floor
Boston, MA 02118

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

E. APPEALS

Applicants may appeal only the following acceptable claims:
- Funding decisions that are 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, and 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 HIV/AIDS Services Division at BPHC (or designee). The written intent to grieve and the request for resolution must be received no later than 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 and to be available to meet at BPHC (see address above). 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.
VIII. APPLICATION AND INSTRUCTIONS

Use **SECTION II: APPLICATION** of this RFP to complete the application. 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.
IX. APPENDICES

APPENDIX A: BOSTON ELIGIBLE METROPOLITAN AREA (EMA) MAP

APPENDIX B: HIV AND AIDS PREVALENCE (BOSTON EMA) & CHARACTERISTICS OF PLWH RECEIVING PART A SERVICES IN 2014

APPENDIX C: HIV CARE CONTINUUM

APPENDIX D: SELECTED HRSA AND BPHC POLICIES & PROCEDURES
# APPENDIX B1: HIV AND AIDS PREVALENCE (BOSTON EMA)

<table>
<thead>
<tr>
<th>Demographic Group/Exposure Category</th>
<th>2012- PREVALENCE AS OF 12/31/12</th>
<th>2013- PREVALENCE AS OF 12/31/13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td>HIV</td>
<td>AIDS</td>
</tr>
<tr>
<td>White, not Hispanic</td>
<td>3,207</td>
<td>3,986</td>
</tr>
<tr>
<td>Black, not Hispanic</td>
<td>2,034</td>
<td>2,921</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1,354</td>
<td>1,922</td>
</tr>
<tr>
<td>Other / Unknown¹</td>
<td>189</td>
<td>242</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,784</td>
<td>9,071</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>HIV</td>
<td>AIDS</td>
</tr>
<tr>
<td>Male</td>
<td>4,759</td>
<td>6,441</td>
</tr>
<tr>
<td>Female</td>
<td>2,025</td>
<td>2,630</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,784</td>
<td>9,071</td>
</tr>
<tr>
<td><strong>Current Age² as of 12/31/2013</strong></td>
<td>HIV</td>
<td>AIDS</td>
</tr>
<tr>
<td>&lt;13 years</td>
<td>25</td>
<td>7</td>
</tr>
<tr>
<td>13 - 19 years</td>
<td>57</td>
<td>18</td>
</tr>
<tr>
<td>20 - 44 years</td>
<td>2,394</td>
<td>1,783</td>
</tr>
<tr>
<td>45 - 64 years</td>
<td>3,823</td>
<td>6,310</td>
</tr>
<tr>
<td>65+ years</td>
<td>485</td>
<td>953</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,784</td>
<td>9,071</td>
</tr>
<tr>
<td><strong>Exposure Category</strong></td>
<td>HIV</td>
<td>AIDS</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>3,008</td>
<td>3,211</td>
</tr>
<tr>
<td>Injection drug users</td>
<td>802</td>
<td>1,704</td>
</tr>
<tr>
<td>Men who have sex with men and inject drugs</td>
<td>222</td>
<td>296</td>
</tr>
<tr>
<td>Heterosexuals³</td>
<td>1,659</td>
<td>2,218</td>
</tr>
<tr>
<td>Other/Unknown⁴</td>
<td>1,093</td>
<td>1,642</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6,784</td>
<td>9,071</td>
</tr>
</tbody>
</table>

¹ Race was either not specified or unknown; includes multi-race (NH)
² Prevalent cases in the New Hampshire counties of the EMA are reported by age at diagnosis for 2012 & 2013
³ Includes presumed heterosexual, where risk of partner is unknown and other primary risk categories have been denied
⁴ Includes hemophilia and cases with identified modes of transmission other than those listed above

SOURCE: MDPH and NHDHHS
### APPENDIX B2: CHARACTERISTICS OF PLWH RECEIVING PART A SERVICES IN 2014

<table>
<thead>
<tr>
<th>Demographic Group/Exposure Category</th>
<th>JANUARY 1, 2014 TO DECEMBER 31&lt;sup&gt;st&lt;/sup&gt; 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MEDICAL CASE MANAGEMENT</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White, not Hispanic</td>
<td>794</td>
</tr>
<tr>
<td>Black, not Hispanic</td>
<td>970</td>
</tr>
<tr>
<td>Hispanic</td>
<td>988</td>
</tr>
<tr>
<td>Other / Unknown</td>
<td>154</td>
</tr>
<tr>
<td>Total</td>
<td>2906</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>MCM</td>
</tr>
<tr>
<td></td>
<td>1845</td>
</tr>
<tr>
<td>Female</td>
<td>1057</td>
</tr>
<tr>
<td>Transgender</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>2927</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;13 years</td>
<td>MCM</td>
</tr>
<tr>
<td></td>
<td>32</td>
</tr>
<tr>
<td>13 - 19 years</td>
<td>27</td>
</tr>
<tr>
<td>20 - 44 years</td>
<td>973</td>
</tr>
<tr>
<td>45+</td>
<td>1895</td>
</tr>
<tr>
<td>Total</td>
<td>2927</td>
</tr>
<tr>
<td><strong>Exposure Category</strong></td>
<td></td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>MCM</td>
</tr>
<tr>
<td></td>
<td>809</td>
</tr>
<tr>
<td>Injection drug users</td>
<td>424</td>
</tr>
<tr>
<td>Heterosexuals</td>
<td>1558</td>
</tr>
<tr>
<td>Perinatal transmission</td>
<td>119</td>
</tr>
<tr>
<td>Hemophilia/coagulation disorder</td>
<td>16</td>
</tr>
<tr>
<td>Through blood, blood products, tissue</td>
<td>51</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>184</td>
</tr>
<tr>
<td><strong>Unique Client Total</strong></td>
<td>2927</td>
</tr>
</tbody>
</table>
The HIV Care Continuum (HCC) also known as the “treatment cascade” is a visual model that shows the 4 main stages people living with HIV go through from the point of their HIV diagnosis to viral suppression.

**Diagnosed:** people diagnosed with HIV infection  
**Linked to Care:** the person visited a health care provider within 3 months after learning they are HIV infected.  
**Retained in Care:** the person had at least two medical visits for HIV care at least 90 days apart, within a 12-month period  
**Virally suppressed:** HIV viral load is less than 200 copies/mL  

The HCC allows local governments, agencies, planning bodies and communities to measure the progress in HIV care for a specific areas and/or target populations as well as to distribute HIV resources more efficiently. Each stage of the HCC, and the comparison among them, provides HIV planners with a clear picture of any gaps that may exist in engaging, retaining, and connecting PLWH to quality care and what needs to be implemented to improve the care PLWH are receiving as they move from one stage to the next.

**National HIV Care Continuum 2011**

The graph above shows people diagnosed with HIV in the United States (US) at each stage of the HCC. The first bar represents everyone in the US that has a known diagnosis. The “N” represents the total number of people diagnosed with HIV. Of the 874,056 people diagnosed with HIV in the country, 75% of those are linked to care, which means that everyone in the second bar (655,542) visited a health care provider within 3 months of being diagnosed with HIV. 50% of people diagnosed with HIV are retained.
in care (437,028), which means that everyone in the third bar had at least two medical visits for HIV at least 90 days apart in 2011, and 24% of people diagnosed with HIV are virally suppressed (209,773), defined as less than 200 copies/mL.


The HCC graph for the Boston EMA (above) shows how the Boston EMA is doing in comparison to the country and also pinpoints specific local gaps in HIV care. The data in the Boston EMA graph is based on the MA statewide HIV Care Continuum. Therefore, it only includes the 7 counties in MA but not the 3 counties in NH. An additional graph has been added describing the NH HIV Care Continuum (below). Within the Boston EMA there were 13,526 people diagnosed with HIV in 2013; 76% of people diagnosed with HIV were engaged in care (10,292) which includes individuals who had at least one visit with their health care provider in 2013. Of the people diagnosed with HIV 61% were retained in continuous care (8,220) which means people in this stage had 2 or more visits at least 3 months apart in 2013, finally 64% of people diagnosed with HIV reported to be virally suppressed (less than or equal to 200 copies/mL) during their most recent draw in 2013. This means that 24% of those diagnosed with HIV were not engaged in care, 39% were not in continued care, and 36% were not virally suppressed.

*Based only on labs received by MDPH

1 MA data includes PLWH who were not incarcerated at the time of diagnosis, diagnosed through 2012 while living in the Boston EMA, alive at the end of 2013, residence based on last known address.
The NH Care Continuum includes all counties in NH; however 65% of the HIV cases in NH are concentrated in the three southern counties that are a part of the Boston EMA. As shown in the graph above NH defines their stages differently than the MA and National cascades. Their definitions are as follows:

- **Diagnosed**: HIV diagnosed as of 9/30/2013 and living with HIV/AIDS as of 12/31/2013
- **Diagnosed and Ever Linked**: HIV diagnosed as of 9/30/2013 and living with HIV/AIDS as of 12/31/2013 who ever had a CD4 or Viral Load (VL).
- **Linked**: “In care cohort”, at least one lab in 2014.
- **Retained**: “In care cohort”, with two CD4 or VL labs in 2014 at least 3 months apart.
- **Suppressed**: “In care cohort”, with the most recent VL at <200 copies/mL.

Of 1,179 people diagnosed with HIV, 98% were ever linked to care, meaning that they had at least a visit (defined as the presence of a CD4 or HIV viral load lab anytime ever) as of December 31, 2013. 72% of people who are “diagnosed and ever linked” are linked which includes individuals who had at least one visit in 2014. 82% of people who are linked are retained meaning individuals who had at least two visits in 2014 at least three months apart, and 90% of people linked are suppressed. There are 28% of people in NH who are not in care which is similar to 24% reported by the 7 Massachusetts counties that are part of the Boston EMA.
| APPENDIX D: SELECTED HRSA AND BPHC POLICIES & PROCEDURES |

The following HRSA and BPHC Policies and Procedures are included in Appendix D:

- HRSA Guidelines for HIV Verification
- Boston EMA Guidelines for HIV Verification
- HIV Testing
- Financial Eligibility for Ryan White Services
- Single Sliding Fee Scale Policy for Ryan White Services
- Client Income Summary Form
- Client Confidentiality Procedures
- Sample Client Acknowledgement Form
- Maintenance of Client Files Policy
- Payer of Last Resort Policy
- Verification of DSM-5 Diagnosis for Part A Funded Mental Health Programs
- Interpretation of the “Federal Public Benefit”
- Definition of “Public Charge” in Immigration Laws

The document HRSA and BPHC Policies and Procedures can be found online at [www.bphc.org/aids](http://www.bphc.org/aids) in the Provider Manual. This document includes the policies and procedures listed above, as well as the following additional policies:

- Use of Part A Funds for Housing Services Policy
- Sample Housing Certification Form
- HRSA Guidelines for Client Sliding Fee Scales
- Federal Fiscal Monitoring Standards
- Managing Rebates Generated from the 340B Drug Reimbursement Program
- Agency Incident Report Procedures
- Contract Transition Policy

**DSS Program Policy Guidance**

No. 1: Eligible Individuals and Services for Individuals Not Infected with HIV

No. 2: Allowable Uses of Funds for Discretely Defined Categories of Services

No. 4: Clarification of Legislative Language Regarding Contracting with For Profit Entities

No. 5: AIDS Drug Assistance Program: Eligibility and Formulary Parity and Uses of Funds

No. 6: Clarification of DSS/HAB Guidance Regarding AIDS Drug Assistance Program: Administration, Eligibility, and Cost-Savings

No. 7: Residence of Planning Council Members and Consortia Members

No. 8: Staff Training

No. 9: Guidelines for Reimbursement of Individuals Serving on a Ryan White Part A Planning Council and/or Part B Consortium

**HAB Policy Notices for the Use of Ryan White HIV/AIDS Program Funds**

11-01: The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-term or Emergency Housing Needs

07-01: The Use of Ryan White Program Funds for American Indians and Alaska Natives and Indian Health Service Programs
07-02: The Use of Ryan White HIV/AIDS Program Funds for HIV Diagnostics and Laboratory Tests Policy
07-03: The Use of Ryan White HIV/AIDS Program, Part B, AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence and Monitoring Services
07-04: The Use of Ryan White HIV/AIDS Program Funds for Transitional Social Support and primary care Services for Incarcerated Persons
07-05: Use of Ryan White HIV/AIDS Program Part B AIDS Drug Assistance Program (ADAP) Funds to Purchase Health Insurance
07-06: The Use of Ryan White HIV/AIDS Program Funds for Outreach Services
07-07: Ryan White HIV/AIDS Program and Veterans
10-01: The Unobligated Balances Provision
Syringe Services Program
Pre-Existing Insurance Program (PCIP)
Portability of Coverage, Enrollee Notices, and Third Party Payments under PCIP
Pre-Exposure Prophylaxis (PrEP)
ADAP/TrOOP
APPENDIX C: HRSA AND BPHC POLICIES AND PROCEDURES

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:

1. 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.
2. 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).
3. 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 agencies and the lack of client eligibility guidelines by the Grantee. 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:

1. Primary documentation of positive HIV serostatus:
   - Any document with medical provider’s (MD, NP (ACRN), PA, RN, pharmacist) signature certifying HIV status,
     a. Examples: letter from provider (on letterhead), copy of HIV-related prescriptions,
   - Lab results (lab slip), or
   - HDAP approval, HOPWA approval or home-delivered meals certification

1. 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.

2. 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:

- 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 PLWH with very limited financial resources.

**Income Threshold**
Effective March 1, 2013 (BPHC) and April 1, 2013 (MDPH), funded providers must screen 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. Agencies may continue to serve individuals with incomes above this level and must not deny services to clients based on income. However, agencies may not use Ryan White funds to serve clients with incomes above the threshold. Agencies 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. Agencies may continue to set lower financial eligibility levels for particular services in consultation with BPHC and MDPH.


**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.

Agencies 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), agencies 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 agency 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, agencies 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 agency policies during routine contract monitoring practices by reviewing documentation in client records.

**Client Income Summary**

Agencies 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, agencies 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. Agencies sharing Client Income Summaries and self-attestation documents do not need to share actual backup income documentation; however, agencies may request this documentation. Agencies should exchange contact information in order to facilitate communication and information-sharing.

Following is an example of how two agencies 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 agencies 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 agency 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 agency 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 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 draft policy describing a local response to the U.S. Health Resources and Services Administration (HRSA) directive to institute sliding fee scales associated with Ryan White services.

Sliding Fee Policy

BPHC and MDPH identified two Ryan White service areas for which a nominal client fee of $10.00 per visit will be instituted: 1) Outpatient/Ambulatory Health Care (Primary Care), and 2) Mental Health. Clients receiving HASD-funded or OHA-funded primary care or mental health services will be charged this nominal fee. Discounts will be applied on a sliding scale dependent on the client’s income indicated in the table below:

<table>
<thead>
<tr>
<th>Client FPL</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100%</td>
<td>No fee</td>
</tr>
<tr>
<td>101 – 200%</td>
<td>5% of fee</td>
</tr>
<tr>
<td>201 – 300%</td>
<td>10% of fee</td>
</tr>
<tr>
<td>301 – 400%</td>
<td>15% of fee</td>
</tr>
<tr>
<td>401 - 500%</td>
<td>25% of fee</td>
</tr>
<tr>
<td>&gt;500%</td>
<td>100% of fee</td>
</tr>
</tbody>
</table>

The federal government has established a cap on annual, aggregate charges to recipients of Ryan White services. These charges include insurance premiums; payments to doctors, dentists, hospitals, pharmacies, and mental health clinicians; premiums and co-pays associated with the HIV Drug Assistance Program (HDAP) - including premiums paid by HDAP; and expenses related to private or public transportation that helps clients travel to and from medical appointments. Caps on out-of-pocket expenses are determined by client income as indicated in the table below:

<table>
<thead>
<tr>
<th>Client FPL</th>
<th>Cap on Out-of-Pocket Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100%</td>
<td>N/A (No Out-of-Pocket Expenses)</td>
</tr>
<tr>
<td>101 – 200%</td>
<td>Actual gross income multiplied by 5%</td>
</tr>
<tr>
<td>201 - 300%</td>
<td>Actual gross income multiplied by 7%</td>
</tr>
<tr>
<td>&gt;300%</td>
<td>Actual gross income multiplied by 10%</td>
</tr>
</tbody>
</table>

Agencies are expected to help clients accessing HASD-funded and OHA-funded primary care and mental health services to understand how the sliding fee scale works and how to track their out-of-pocket expenses. BPHC and MDPH have created a sample form that clients can use for this purpose.
Client Income Summary

Agencies may use or adapt the BPHC and MDPH Client Income Summary to record the client’s income, FPL, and – if receiving HASD-funded or OHA-funded primary care or mental health services - cap on out-of-pocket expenses. This form is intended to help facilitate access to other Ryan White 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. With appropriate releases of information, agencies working with common clients can coordinate ongoing six-month eligibility screens, share documentation of income, and assess eligibility without requesting the same information directly from the client.

For example, a client’s Medical Case Management (MCM) provider may screen for financial eligibility and complete the Client Income Summary with a client. The MCM provider may then refer the client for congregate meals. The client or MCM provider can give this Client Income Summary to the congregate meals provider along with a signed release of information form. The agencies can communicate about who will complete the financial eligibility screens every six months (in most cases, the MCM provider), and will decide how to share results and documentation on a routine basis.

Monitoring

HASD and OHA staff will assess compliance with agency policies during routine contract monitoring practices by reviewing documentation of the use of the sliding fee scale, and the application of caps on out-of-pocket expenses.
APPENDIX C: HRSA AND BPHC POLICIES AND PROCEDURES

CLIENT INCOME SUMMARY FORM

Client Income Summary

The purpose of this form is to document financial eligibility for Ryan White HIV/AIDS Program services. The form can be shared among service providers to verify income screening if the client has signed and dated a release of information document. This form is valid for six months after the screening date.

<table>
<thead>
<tr>
<th>Agency name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency phone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client name:</th>
<th>Client Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screening date:</th>
<th>Expiration date (six months after screening):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Annual income:
To determine if the client’s gross annual income is less than 500% of the FPL, if the client provides a pay stub, the gross year-to-date ("YTD") is used to calculate gross annual income. If the pay stub does not show gross YTD, the client must provide two pay stubs, so that yearly gross earnings can be calculated using the client’s average earnings for the designated pay period. If the client is not working, but receives SSI, SSDI, or any other type of monetary benefit, proof of this must also be shown. If the client is not working and has no income, or if he/she is working but cannot provide proof of this, a letter from the client’s medical case manager is required. If the client does not have a medical case manager, then a letter from his/her clinician is required. If a client is over-income, check to see if the client has dependents. If so, documentation must be provided (usually a copy of page one from the most recent U.S. 1040 tax return, if available), and an additional $4,160 (as of 2015) is then allowed for each dependent.

CLIENT ANNUAL INCOME: $ 

Documentation provided for client record (check all that apply):
☐ Pay stub(s) ☐ Social Security Administration (SSDI/SSI) letter ☐ Private disability statement
☐ Department of Transitional Assistance (TANF/EAEDC) letter ☐ Veterans’ Benefits
☐ Other: ________________

Federal Poverty Level:
Consult the U.S. Department of Health and Human Services poverty guidelines for the current calendar year at http://aspe.hhs.gov/poverty. Based on the client’s gross annual income, what is the applicable Federal Poverty Level (FPL) range? [FPL: ____ %]

Signatures:
Client: __________________________ Date: __________________
Agency staff (person completing the form): ______________________ Date: __________________
Title: _______________________________

Updated 9-15-15
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 agencies, *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.
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. Further clarification is found in the Standards of Care.

<table>
<thead>
<tr>
<th>Certification Forms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUTHORIZATION TO OBTAIN/RELEASE OF INFORMATION</strong></td>
<td>Programs must have a release of information form that describes under what circumstances client information can be released. A release of information should include: name of agency/individual with whom the information will be shared; information to be shared; duration of the release consent; client signature; date signed; and expiration date. A Release to multiple providers is allowable.</td>
</tr>
<tr>
<td><strong>CLIENT ACKNOWLEDGMENT OF FILE REVIEW</strong></td>
<td>Programs must have an acknowledgement form that informs clients that BPHC will review client files on site during site visits.</td>
</tr>
<tr>
<td><strong>HIV VERIFICATION</strong></td>
<td>Programs must have documentation of each client’s HIV status. Primary documentation may include lab slips, HIV test results, and/or medical provider statements acknowledging HIV status.</td>
</tr>
<tr>
<td><strong>INCOME VERIFICATION</strong></td>
<td>Programs must have documentation of each client’s income. Examples of acceptable documentation of income include copies of SSI/SSDI statement(s), pay stubs, MassHealth card, or letter written and signed by provider stating the client has no source of income.</td>
</tr>
<tr>
<td><strong>FINANCIAL ELIGIBILITY</strong></td>
<td>Programs must have documentation of each client’s financial eligibility for Part A services. Eligibility thresholds for Part A for Boston EMA clients are 500% of Federal Poverty Level (FPL); clients who are above this threshold are not eligible for Part A services. However, clients may still opt to receive services from that site, but the provider must use other funding streams to do so. Providers must complete the Client Income Summary Form (or approved agency form) at intake/assessment and every six months thereafter to verify client’s continued eligibility for services. If a client cannot provide a form of documented income, a letter written and signed by a case manager stating that the client has no income is sufficient. This letter must be accompanied by a completed Client Income Summary Form (or approved agency form) showing that the provider assessed all forms of financial supports and properly assigned the client to the appropriate FPL.</td>
</tr>
<tr>
<td><strong>GRIEVANCE PROCEDURE</strong></td>
<td>Programs must have evidence that client was informed of and understands the agency’s grievance procedure. An agency grievance procedure ensures that clients have recourse if they feel they are being treated in an unfair manner or do not feel they are receiving quality services. A grievance procedure should include: how to file a grievance; to whom the grievance should be addressed; an alternative addressee if the client does not choose to speak with first designee; how the grievance will be handled; description of reasonable timeliness for processing the grievance; a step-by-step filing process if grievance remains unresolved.</td>
</tr>
</tbody>
</table>
Programs must document each client’s proof of residency at least once every 6 months. Proof of residency can be in the form of: a driver’s license, utility bills, bank statement, real estate tax bill or receipt, a current residential lease, a pay check or a government check or other document issued by a unit of government, or a signed case manager letter on the organization letter head verifying the town and postal code of residence.

Programs must have documentation in every client file to certify that housing assistance is essential to the client’s ability to gain and/or maintain access to HIV related medical care or treatment.

Programs must have documentation of DSM-5 diagnosis for each Part A funded client. A letter from BPHC regarding this requirement can be found on page 98.

Programs must have documentation of each client’s insurance status. Types of insurance coverage can include public (Medicare, Medicaid/MassHealth, Commonwealth Care), private (employer-based, private non-group, COBRA, or subsidized private plans via Commonwealth Choice), or other types of coverage (VA Benefits). If a client is not eligible for any existing insurance plans, then the provider should document the reason and how the client will access medical services and prescription drugs.

Programs must have documentation for each client of the following components:

- DATE OF INTAKE
- REFERRAL SOURCE
- AGE
- GENDER
- RACE/ETHNICITY
- PRIMARY LANGUAGE,
- EXPOSURE CATEGORY
- DIAGNOSTIC INFORMATION
- ZIP CODE
### Coordination of Services

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>Programs must have completed assessments which include the following: medical history and health status, available financial resources, availability of food, shelter, transportation and financial resources, and need for legal assistance if necessary. BPHC and MDPH have developed a recommended assessment form for MCM programs, which is available on BPHC’s website.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE CARE PLAN</td>
<td>Programs must have service care plans which should be developed collaboratively with the client. Service care plans should include a description of specific client needs, goals and objectives, available resources to address the needs, and timelines for implementation. Service care plans must be signed and dated by the client.</td>
</tr>
<tr>
<td>PROGRESS NOTES</td>
<td>Programs must have progress notes which are related to the service care plan and show evidence of referrals and follow-up actions. Progress notes should be dated, legible, and organized appropriately and chronologically.</td>
</tr>
<tr>
<td>REASSESSMENT AND UPDATED SERVICE CARE PLAN</td>
<td>Programs must have client reassessments and updated service care plans. These forms must be updated with clients at least once every 6 months. BPHC and MDPH have developed a recommended reassessment form for MCM programs, which is available on BPHC’s website.</td>
</tr>
<tr>
<td>SUPERVISORY REVIEW</td>
<td>Programs must have evidence of supervisory review in client files. This may be noted through signed service care plans, signed progress notes and/or a signed review sheet that is maintained in the front of the client file.</td>
</tr>
</tbody>
</table>
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.
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.
DEPARTMENT OF HEALTH & HUMAN SERVICES

PUBLIC Health Service

Health Resources and
Services Administration
Rockville MD 20857

AUG 10 1998

PI/PROJ-DIR: STEVENS, RICHARD
BOSTON PUBLIC HEALTH COMMISSION
PUBLIC HEALTH
1 BOSTON MEDICAL CENTER PLACE
BOSTON, MA 02118

Dear Program Grantee:

SUBJECT: Guidance on the Interpretation of "Federal Public Benefit"

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, restricts access to "Federal public benefits" to qualified aliens.

In an August 4, 1998 Federal Register notice, the Department of Health and Human Services identified 31 programs that provide "Federal public benefits." The service delivery programs of the Health Resources and Services Administration are not among the 31 programs listed in the notice since it has been determined that they do not provide "Federal public benefits" as defined in Title IV of PRWORA. Therefore, these programs are not subject to the PRWORA requirement and are not required to verify the immigration and citizenship status of their patients. The Federal Register is available on GPO Access at: "www.access.gpo.gov/nara".

I am pleased to be able to provide this long awaited information to you:

Sincerely,

Claude Earl Fox, M.D., M.P.H.
Administrator
DEFINITION OF “PUBLIC CHARGE” IN IMMIGRATION LAWS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and Services Administration
Rockville MD 20857

MAY 26 1999

06-09-99P04:13 RCVD

Dear Program Grantee/State Agency:

SUBJECT: Guidance on definition of “public charge” in immigration laws

The Department of Justice (DoJ) published in the Federal Register on May 26, 1999, a Notice of Proposed Rulemaking (NPRM) that establishes clear standards governing whether an alien is inadmissible to the United States, ineligible to adjust immigration status, or has become deportable on the grounds that he or she is likely to be or is a “public charge.” The Immigration and Naturalization Service (INS) also published Field Guidance in the same Federal Register, and the Department of State (DoS) has issued a cable to all embassies implementing immediately the policy set forth in the NPRM.

There has been some confusion among immigrant families and service and benefit providers regarding how the receipt of different benefits and services by immigrants and their family members will be treated for public charge purposes. The NPRM, along with the INS and DoS guidance, clarifies the limited number of benefits that may be considered by immigration officials in making public charge determinations.

The DoJ proposes to define public charge to mean an alien who has become (for purposes of deportation) or is likely to become (for purposes of admissibility or adjustment) “primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense.” Cash benefits for income maintenance include the following: (1) Supplemental Security Income (SSI); (2) Temporary Assistance for Needy Families (TANF), but not including supplemental cash benefits excluded from the term “assistance” under TANF program rules or any non-cash benefits and services provided by the TANF program; and (3) State and local cash benefit programs that are for the purpose of income maintenance (often called “General
Assistance but which may exist under other names). The sole exception to the focus on cash assistance is an instance in which Medicaid or a related program would meet this definition by paying for the cost of a person’s institutionalization for long-term care. The NPRM and Guidance clarify that receipt of cash welfare assistance (SSI, TANF, or State/local equivalents) cannot automatically result in a public charge inadmissibility determination. The INS and DoS officers must still apply a “totality of the circumstances” test which may include receipt of cash assistance for income maintenance purposes, but also must include several mandatory factors, including age, health, family status, assets and resources, financial status, education, and skills.

The HRSA grant programs are not listed above and are not identified in the INS or DoJ guidance as providing a cash benefit for income maintenance purposes. Accordingly, a noncitizen cannot receive services under these programs and such receipt will not be considered by immigration officials as part of the public charge determinations.

Because this policy area is complicated, we encourage grantees to become familiar with the NPRM and Field Guidance published in the Federal Register. We are also enclosing a short summary of the new policy and a set of frequently asked questions and answers to help grantees/agencies better understand the details of these new public charge policies and which noncitizens may be affected. These materials, as well as the DoJ regulation and the INS guidance, can be found on the HRSA website @http://www.hrsa.gov.

Sincerely,

Claude Earl Fox, M.D., M.P.H.
Administrator

Enclosures
RYAN WHITE HIV/AIDS TREATMENT
EXTENSION ACT PART A

Fiscal and Program Rules FY 2015

HIV/AIDS Services Division
Boston Public Health Commission
1010 Massachusetts Avenue, 2nd Floor

Boston, MA 02118
The Boston Public Health Commission expects that all Part A contracted providers will expend 100% of their award in accordance with all federal, local, and BPHC policies. BPHC will only reimburse providers for deliverables that have been mutually agreed (see Scope of Services and Budget) upon receipt of appropriate invoices and back-up documentation. If the provider 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 program/agency audit be submitted. Failure to meet these expectations may result in suspension or termination of your provider contract.

A. Invoicing

General Information

1. A standard invoice including the approved budget must be submitted. Part A payments for cost reimbursement and unit rate contracts are based on the approved budget. Invoices must be formatted by computer; handwritten invoices are not acceptable. Please note there cannot be anything handwritten on an invoice. Only line item budgeted expenses are reimbursed.

2. All contracts must have their invoices signed by a program representative or a contract specialist before submission to the Part A program.

3. Invoices are submitted monthly, within 15 days of the month's end. Invoices must represent actual monthly expenses. The final invoice is to be submitted by March 15, 2016. Each day thereafter will be considered late, therefore non-compliant.

4. Invoices without the required information or documentation (including required data and reports) will not be processed. Instead, the agency is informed of the deficiency to be corrected, and the invoice is held for five business days. If there is no response after five business days, the invoice is deleted and the agency will need to resubmit the invoice.

5. An invoice must be submitted to the BPHC for each month in the contract period. If no contracted activities occurred in a given month, there would be no reimbursable costs; an invoice with a $0 monthly total must be submitted.

6. 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.

7. Monthly invoices containing all required information will be paid within 30 days of receipt. Payment will be held if complete quarterly reports are not received when due and/or if fiscal documentation is incomplete; agencies are informed in writing.

8. Invoices are sent to:
   Accounts Payable
   Boston Public Health Commission
   1010 Massachusetts Ave, 2nd Floor
   Boston, MA 02118
   Or,
   Accountspayable@bphc.org
   CC: All Ryan White Fiscal Staff
Cost Reimbursement Invoicing

1. Appropriate supporting documents for monthly cost reimbursement invoices include:
   - Payroll registers and labor reports
   - Purchase requisitions accompanied with vendor invoice copy
   - Cancelled checks
   - Copies of vendor invoices
   - Copies of reimbursement/voucher forms

2. The budget on the invoice must illustrate the exact approved contract budget. The name of each staff member must be noted next to each position on the budget. Actual monthly payroll expenses paid (not accrued) are billed on the invoice. The year-to-date amounts in the “Cumulative” billing column must be correct. Also, the salaries and FTEs which are billed must correspond to the approved contract budget. If any of these are incorrect on an invoice, it will not be processed. A budget revision request and/or revised invoice may be submitted.

3. The fringe rate must be the internally audited fringe rate. Verification of this rate is subject to audit. (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 is required for any invoices submitted for the purchase of client related travel, meals/food, and other client consumables in below line items on any program budget:
   - Itemized receipts must include the merchant or provider name, service received or specific item purchased, date of service and amount of expense.
   - 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).

These are required at the time of billing for all (but not limited to) the following line items:
- Food provided with client activities (e.g., Psychosocial Support group meals)
- Taxi vouchers
- The Ride tickets
- Commuter rail
- Bus and subway fare
- Volunteer mileage
- Contracted services rides

A sample itemized list for transportation, and rental assistance is as follows:

<table>
<thead>
<tr>
<th>Client Code/ UCI</th>
<th>Unit of Service Code</th>
<th>Date</th>
<th>Unit of Service</th>
<th>Amount</th>
<th>Vendor</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAR0609547899/</td>
<td>4271</td>
<td>03/04/15</td>
<td>Rental Assistance</td>
<td>$300</td>
<td>Century 21</td>
</tr>
<tr>
<td>RSCR0609542</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAR0609547899/</td>
<td>4442</td>
<td>03/12/15</td>
<td>Taxi to Medical Appointment</td>
<td>$22.50</td>
<td>Boston Taxi</td>
</tr>
<tr>
<td>RSCR0609542</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note: RENTAL ASSISTANCE may not be used for mortgage payments or back rent.
Programs will be allowed to utilize resources to pre-purchase food, tokens, and taxi vouchers if done so by **December 15, 2016**.

5. The following must be submitted before billing for a consultant line:
   - A resume and list of qualifications for any consultant hired.
   - A detailed description of the services/activities performed by the consultant.
   - The consultant’s last name must be indicated on the invoice cover sheet when an invoice is submitted.

6. Contracts can only include an “Indirect” line item (capped at 10%) if the provider has a certified HHS-negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certification of Indirect Costs, or adhere to a 10% cap on administrative expenses.

7. Vehicle mileage is reimbursed at a per mile rate not to exceed the Internal Revenue Service’s standard mileage rate, **which as of January 1st, 2014 is currently $0.56 per mile**.

8. Travel outside of the EMA is not allowed and will not be reimbursed. Exceptions to this may be made with the written prior approval from the HIV/AIDS Services Division, where travel outside the EMA is for necessary trainings which may be held in various parts of the state.

**Unit Rate Invoicing**

1. Unit rate billing uses the non-personnel expense portion of the standard Part A invoice (bottom half).

2. Unit rate billing documentation differs from Cost Reimbursement in that service utilization data serves as the fiscal backup documentation for units billed. Billing backup can be a direct print out from the e2Boston data system or prepared as shown in the example below.

<table>
<thead>
<tr>
<th>Client Code/UCI</th>
<th>Unit of Service Code</th>
<th>Date</th>
<th>Unit of Service</th>
<th># of units</th>
<th>Rate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAR0609547899/ RSCR0609542</td>
<td>4703</td>
<td>03/05/15</td>
<td>Bed Day, RRS</td>
<td>30</td>
<td>$75</td>
<td>$2,250</td>
</tr>
</tbody>
</table>

**Fiscal Compliance**

1. 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. This includes the need to return unexpended dollars to the federal government. Therefore, all programs are expected to expend 100% of their contracted award. Contract expenses, as shown on invoices, are reviewed each quarter of the fiscal year. The agency is informed after the first quarter, in writing, of any under billing. Any contract under billed through the second quarter may be reduced. If the under billing is due to a late start, the contract is reduced by the amount of the unspent funds to date. If the under billing is chronic, the contract is reduced by both the unspent funds and the projected under spending to year-end. These unexpended funds are then reallocated to other provider contracts in accordance with the Ryan White HIV Services Planning Council’s service priorities. Reallocations within individual categories and the resulting contract revisions do not require Planning Council approval.
2. In addition, the program may be held in non-compliance at the end of each month if they do not meet the invoicing requirements. This includes non-submission of invoices, or late invoices. If the invoice is incorrect and/or incomplete, it will be returned to the agency and the agency will be required to submit new corrected information. Agencies are notified of non-compliance in writing. Non-compliance shall be lifted as soon as all submissions are complete.

3. On a case by case basis, contract spending may differ from each personnel line item by no more than 10% monthly, for example if you are projected to bill a monthly salary of $500 (annual salary of $6,000), you may spend $550 within that line per month (therefore, cannot exceed $6,600 annually) with the sufficient back up. For below line items, e.g. if you are budgeted for a $1,000 office supply line for the year, you may spend up to $1,100 within that line (you many bill this in one month or it may divided between several months). Both of these stipulations are as long as the total amount billed does not exceed the budget’s maximum obligation. Overspending will not be reimbursed.

4. 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”.

C. Audits

Agencies must perform audits of agency financial records as described in the OMB Circular A-133 if they receive more than $500,000 in federal funding. For agencies that receive less than $500,000 in federal funding, the agency is required to have annual audits and financial statements prepared by independent auditors.

When completed, this audit must be sent to:

William Kibaja, Director of Budgets and Grants
Boston Public Health Commission
1010 Massachusetts Ave, 2nd Floor
Boston, MA 02118

In addition, this audit and all required fiscal records must be available at the program location for review during the on-site financial review.

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 line 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 agency. Complete instructions are available under the budget revision section of the manual.

2. Agency requests to revise contract budgets are made in writing to:

Eric Thai
Interim Client Services Director
Boston Public Health Commission
1010 Massachusetts Ave, 2nd Floor
Boston, MA 02118
3. Budget revision requests must include the following: (1) a letter with a detailed explanation for making the proposed revision; (2) a current budget with the proposed changes made in the same format; and (3) a detailed line item budget explanation attached.

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, agencies are allowed to shift funds between existing line items due to evolving service needs.

5. **Budget revisions will not be accepted after December 15, 2016.**

6. Initial appeals of denied budget revision requests are made, in writing, to the Client Services Director. Further appeals may be submitted, in writing, to the Director of the Infectious Disease Bureau, Dr. Anita Barry.

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/AIDS 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. **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** (without regard to whether any of these Subcontractors expend more or less than 10 percent 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 must enter into an agreement with a public or private entity to provide the service. The Subcontractor 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 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 PLWH. Applicants are reminded that Part A Grantees/Sub-Grantees are subject to audit on this and other restrictions on use of funds.

8. 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 below). 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.

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

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 provided is accurate.

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 local (within the EMA) and directly related to the services provided under the specific contract.
Reporting

A. Reporting shall be considered a deliverable under this agreement for purposes of determining fulfillment of the Subcontractor’s obligations. Failure to produce timely and adequate reports may jeopardize the Subcontractor’s funding during the current award period, as well as its eligibility or consideration for funding in subsequent years, and shall result in a delay in payment.

Furthermore, BPHC reserves the right to withdraw an award if it determines the Subcontractor has failed to make substantial progress on its goals and objectives, that such failure is unreasonable, and the Subcontractor does not demonstrate an adequate strategy to address obstacles to that progress.

B. The Subcontractor shall submit quarterly narrative progress and statistical reports in writing. Statistical reports shall include, at a minimum, the submission of (1) Client Information: including a unique client code, client demographics, exposure category, diagnostic information, housing status, and insurance status, and (2) Client Utilization Data: including units of service delivered, dates of service, and number of units. Such submissions must be made via BPHC’s e2Boston System. Narrative reports shall include a description of the progress made and efforts undertaken to meet goals and objectives for each activity or service funded, including summary of services provided and those served (Service and Demographic report), any problems, obstacles or barriers to meeting such goals and objectives, and any actions taken or to be taken to resolve such problems, obstacles, or barriers. Quarterly narrative reports should also include updates on personnel changes for Part A staff and a description of any program spending issues during the reporting period. BPHC may request additional information at any time.

C. All quarterly reports shall contain narrative descriptions that are concise and informational, including sufficient detail to allow evaluation of funded efforts. Tables and exhibits may be substituted for narrative descriptions, where appropriate. Also, the Subcontractor shall include a description of the implementation and progress on any Plans of Corrective Action submitted to the Boston Public Health Commission. Furthermore, while funding through other sources that complement Part A funded activities may be cited, the application of Part A funds shall be made explicit and documented separately in reports. The Boston Public Health Commission may provide specific formats for submitting reports, which the Subcontractor shall be required to follow. The Subcontractor shall be required to adhere to new reporting requirements in submitting their quarterly reports subsequent to that date. Training will be provided.

D. Quarterly reports shall be submitted within fifteen (15) days after the end of the quarter. If applicable, annual reports shall be submitted within fifteen (15) days of the close of the reporting period. All reports shall be submitted to the Boston Public Health Commission.

E. Programs funded with unit rate contracts must submit a combined fiscal and data report within fifteen (15) days after the end of each month, and a quarterly narrative report within fifteen (15) days of the close of each quarter.

F. Client level outcome measures have been developed for all service categories. Subcontractors shall submit reports on outcome measures within fifteen (15) days after the end of the 2nd and 4th quarters.

G. All Subcontractors will be expected to complete the Ryan White HIV/AIDS Services Report (RSR) each calendar year. Additional information will be provided prior to submission.
H. All subcontracts will be expected to comply with the specific requirements detailed in the *National Monitoring Standards for Ryan White programs*.

**Monitoring**

BPHC or other entities on behalf of BPHC will conduct site visits. The Subcontractor will receive no less than one (1) site visit during the period of performance. Site visits include a review of both fiscal and programmatic documentation. Key personnel involved in implementation of the Scope of Services at any and 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 prior to, at, or subsequent to the site visit(s). The Subcontractor will have a reasonable time to produce such information. The Subcontractor will also receive reasonable notice prior to each site visit. The Boston Public Health Commission 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 Boston Public Health Commission also has the right to visit at a time of its choosing and without advance notice.

**Income Eligibility**

The subcontractor will be expected to comply with the *Financial Eligibility Policy for Ryan White Services* which requires funded providers to screen HIV + clients 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 subcontractor will also adhere to the *Ryan White Services Sliding Fee Scale Policies*, as indicated by BPHC.