

APPENDIX A: Program Requirements for FY2010 Service Delivery and Administrative Contracts

A. DESCRIPTION OF SERVICE COMPONENTS

Federal and state funds are made available to local areas to provide comprehensive outpatient health and support services for individuals with HIV and to administer these funds. Eligible services to be provided or administered with state and federal resources allocated for medical and psychosocial support services are catalogued and defined at <http://www.dshs.state.tx.us/hivstd/taxonomy/taxonomy.pdf> descriptions of administrative services are found in Appendix B.

B. REQUIREMENTS FOR ADMINISTRATIVE AGENCIES

The roles of the Administrative Agency (AA) include administration, planning, evaluation, and quality management. All AAs must provide all these services. These activities are defined as follows:

1. Administrative Functions

Through a contract with DSHS, assist DSHS in providing grant administration for available federal and State HIV services and HOPWA funds, including:

- a) developing funding applications and proposals;
- b) receipt and disbursement of program funds, including identification of providers in each community to be served who are best suited to provide the funded services through DSHS- approved procurement processes such as requests for proposals, and execute contracts for these client services;
- c) developing and establishing reimbursement, accounting and financial management systems;
- d) preparing routine financial data and reports as required by DSHS;
- e) implementation of the service delivery plan for the area;
- f) compliance with contract conditions and audit requirements;
- g) subcontract monitoring and reporting, through telephone consultation, written documentation and on-site visits, for programmatic and financial contract compliance, quality and process improvement. This includes monitoring of clinical and case management services;
- h) ensuring that the service needs of all clients are provided through subcontractors who are culturally, ethnically, and linguistically sensitive to these populations;
- i) staff training associated with administrative functions.

2. Capacity Building

- a) capacity building to increase the availability of services
- b) technical assistance to contractors including clinical and case management services
- c) ensure that services are accessible to the populations to be served
- d) assure that the care offered by providers meets current standards of care and treatment of persons with HIV.

3. Needs Assessment/Planning/Evaluation Functions

- a) Assessing service needs, barriers to services, services gaps, and unmet need for HIV-related medical care within the HIV Administrative Service Area.
- b) Developing an annually updated comprehensive plan for delivery of HIV medical and psychosocial support services, including priorities and allocations, that is data-driven and shaped by community input. The plan should contain goals with related

measurable objectives and address issues included in the Texas Statewide Coordinated Statement of Need as relevant for the area.

- c) Periodic examination of utilization and expenditure data, making reallocations as necessary;
- d) Establishing multiple mechanisms for stakeholder input into the development of the HIV services delivery plan;
- e) Collecting data on the outcomes of service delivery as specified by DSHS ;
- f) Evaluation of the cost-effectiveness of the mechanisms used in the delivery plan ;
- g) Periodic evaluation of the success of the service delivery plan in responding to identified needs;
- h) Maintaining complete, accurate and timely client-level programmatic data, including adhering to the minimum requirements of maintaining the URS as required by DSHS. This includes contract set up for providers with Part B Minority AIDS Initiative (MAI) funds, and technical assistance on URS participation for these providers.

4. Quality Management Functions

Quality Management is a mandated function in the Ryan White Program. The standards apply to RWAA, RWSD, SS, and MAI scopes of work. Quality Management Systems require:

- a) The presence of a documented, ongoing quality management system that is used to guide and continuously improve the program
- b) A QA/QI/PI committee function that includes documented membership, member roles, responsibilities, meeting frequency, and minutes of each meeting;
- c) Significant participation by physician in quality management functions;
- d) Evidence of actions to measure, monitor and improve quality of care, including client utilization data and improvements in accessibility, availability, continuity, effectiveness, efficiency, patient satisfaction, timeliness of care, environmental safety, health disparities or other quality indicators of services;
- e) Programmatic, financial, operational and other applicable data analysis in order to identify issues that impact the quality of services;
- f) AA administered client satisfaction surveys and follow up on all identified issues from the surveys with supported documentation of improvement and re-evaluation of those issues;
- g) The identification of outcomes and efforts at improving them through the utilization of goals and measurable objectives with associated strategies (a QI/QM Improvement Plan) to accomplish the ongoing improvement, inclusive of a QI/QM work plan;
- h) Identification, monitoring and correction of adverse outcomes;
- i) Contractor oversight compliance monitoring system, including documented corrective action, review, evaluation and follow up;
- j) Contractor participation in the ongoing quality management system, including an well developed provider feedback loop;
- k) Review, tracking and analysis of client, staff and subcontractor grievances;
- l) Evidence of programmatic and management improvements, including documented revisions to program administration, policies and procedures, committee actions and other applicable initiatives impacting quality of services;
- m) An annual evaluation summary of the quality management system (internal and external);
- n) An annual evaluation of agency policies and procedures and

- o) A process for development and an annual review of clinical protocols and Standing Delegation Orders (SDOs);
- p) Review of the Comprehensive Services Plan for the area.

C. USE OF FUNDS

1. Allowable use of funds

Contract funds may be used for personnel, fringe benefits, equipment, supplies, staff training, travel, contractual or fee-based services, other direct costs, and indirect costs. **For the purposes of insurance assistance, contract funds may be used for the payment of insurance premiums, deductibles, co-insurance payments, and related administrative costs.** Equipment purchases are allowed if justified and approved in advance. All costs are subject to negotiation with the DSHS.

Contractors are required to adhere to federal principles for determining allowable costs. Such costs are determined in accordance with the cost principles applicable to the organization incurring the costs. The kinds of organizations and the applicable cost principles are set out in the DSHS contract general provisions and in the *DSHS Contractors Financial Procedures Manual*. Copies are available online at <http://www.dshs.state.tx.us/contracts/cfpm.shtm>.

If the contractor expends \$500,000 or more in total federal financial assistance during the contractor's fiscal year, arrangements must be made for agency-wide financial and compliance audits. The audit must be conducted by an independent certified public accountant and must be in accordance with applicable Office of Management and Budget (OMB) Circulars, Government Auditing Standards, and the applicable Uniform Grant Management Standard (UGMS) State Audit Circular. Contractors shall procure audit services in compliance with state procurement procedures, as well as the provisions of UGMS. If the contractor is not required to have a Single Audit, DSHS will provide the contractor with written audit requirements if a limited scope audit will be required.

The administrative agency must:

- ensure that each subcontractor obtains a financial and compliance audit (Single Audit) if required by OMB Circular A-133 and/or UGMS,
- ensure that subcontractors who are required to obtain an audit take appropriate corrective action within six months of receiving an audit report identifying instances of non-compliance and/or internal control weaknesses, and
- determine whether a subcontractor's audit report necessitates adjustment of the administrative agency's records.

2. Disallowances

Funds provided through RWSD, SS, or HOPWA contracts may not be used for the following:

- expenses of the Administrative Agency
- to make cash payments to intended recipients of services, except for reimbursement of reasonable and allowable out-of-pocket expenses associated with consumer participation in planning activities;
- for acquisition of real property, building construction, alterations, renovations, or other capital improvements; and
- to supplant other funding for services already in place; and

- funds provided through the RWAA contract may not be used for direct client services.

3. Program Income

All fees collected for services provided by Ryan White and SS funds are considered program income. All program income generated as a result of program funding must be proportionately integrated into the program for allowable costs and deducted from gross reimbursement expenses on the voucher before requesting additional cash payments. All program income must be reported on the quarterly financial reports. The *DSHS Contractor Financial Procedures Manual* contains additional information on program income. This document is available on the DSHS Contract Oversight and Support (COS) Division website at: <http://www.dshs.state.tx.us/contracts/cfpm.shtm>.

4. Payor of Last Resort

The costs of delivering services should be reasonably shared by the state and federal governments, private health insurers, and to the extent possible, by the client within the limitations set in the Charges to Clients for Services section below. To maximize the limited program funds, Ryan White CARE Act funds should be considered payor of last resort.

It is the responsibility of the AA to ensure that:

- Providers bill all potential third party payors for applicable services provided;
- Costs incurred from the billing process are not be charged to the client in whole or in part;
- Funds are 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 payors, including Medicaid, Medicare, other state or local entitlement programs, prepaid health plans, and/or employment-based health insurance;
- Providers pursue the process to bill Medicaid, employment-based health insurances and other publicly-funded health insurance programs;
- Providers screen all clients for employment-based health insurance, potential Medicaid and other publicly-funded health insurance benefits and actively promote successful client enrollment in Medicaid and other third party payor sources for which clients may be eligible (Medicare, CHIP, etc);
- Providers who, with adequate justification, cannot bill a particular third party payor held within their client caseload applies for a waiver;

Note: Providers are subject to audit on this and other restrictions on use of funds.

5. Charges to Clients for Services

It is the responsibility of the AA to ensure that:

All providers develop and implement a fee for service system, such as a sliding scale fee or client co-payment, using the federal poverty guidelines.

Individual, annual aggregate charges to clients receiving Part B services must conform to limitations established in the table below. The term, "aggregate charges" applies to the annual charges imposed for all such services under this Title of the Act without regard to whether they are characterized as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges for services. This requirement applies to all service providers from which an individual receives Part B-funded services.

Clients must be charged a fee when receiving ambulatory outpatient medical care. Service providers of ambulatory medical care may determine a fee for client without a third party payor through use of a sliding scale, or flat fee system. The fee charged to clients with a billable third party payor will be determined by the third party payor.

Individual/Family Annual Gross Income and Total Allowable Annual Charges

An eligibility assessment done of each client will provide annual gross salary of the individual/ family as the baseline by which the caps on fees will be established. The client should assure that the information provided is accurate. The intent is to establish a ceiling on the amount of charges to recipients of services funded under Part B. Please refer to the following chart for allowable charges.

INDIVIDUAL/FAMILY ANNUAL GROSS INCOME	TOTAL ALLOWABLE ANNUAL CHARGES
Equal to or below the official poverty line	No charges permitted
101 to 200 percent of the official poverty line	5% or less of gross income
201 to 300 percent of the official poverty line	7% or less of gross income
More than 300 percent of official poverty line	10% or less of gross income

D. MEDICAID PROVISION

It is the responsibility of the AA to ensure that:

A subcontractor/service provider not currently designated as a Medicaid provider must apply to be a Medicaid provider.

Subcontractors/service providers who cannot meet eligibility requirements to become Medicaid providers for applicable program activities may apply for a waiver. Waivers may be granted pending approval by DSHS of adequate justification provided by the performing agency. Examples of adequate justification include but are not limited to: evidence of denial by Medicaid, evidence that implementing this requirement would result in a loss of critical HIV/STD services to the community, or evidence that implementing this requirement would result in a substantial detriment to the health of a client with HIV/AIDS.

E. PROTOCOLS, STANDARDS AND TREATMENT GUIDELINES

Client services contractors are required to conduct project activities in accordance with the Quality Care: DSHS Standards for Public Health Clinic Services manual. A copy is posted on the DSHS website at <http://www.dshs.state.tx.us/qmb/dshsstndrds4clinicservs.pdf>. Contractors are required to conduct project activities in accordance with various federal and state laws prohibiting discrimination. Guidance for adhering to non-discrimination requisites can be found on the following website <http://www.hhs.state.tx.us/aboutHHS/CivilRights.shtml>

Additionally, applicants who provide direct client services are required to adopt written

protocols, standards and guidelines based on the latest medical knowledge regarding the care and treatment of persons with HIV infection. These include the standards found at the following link: http://www.dshs.state.tx.us/hivstd/clinical/pdf/contract_reqs.pdf

Current, federally approved guidelines for clinical treatment of HIV and AIDS are available from the HIV/AIDS Treatment Information Services (ATIS) at <http://www.hivatis.org>; and on the HIV/STD Prevention and Care Branch website at http://www.dshs.state.tx.us/hivstd/clinical/pdf/contract_reqs.pdf PERFORMING AGENCY is responsible to maintain access to current standards and guidelines.

F. ASSURANCES AND CERTIFICATIONS

Contractors must submit with the application and maintain on file current, signed, and annually-dated assurances adhering to the following:

- Nonprofit Board of Directors and Executive Officer Assurances, if the Administrative Agency is a nonprofit organization,
- HIV Contractor Assurances, and
- Contractor Assurance Regarding Pharmacy Notification.

Copies of each form listed above are provided in this application. Other assurances are included in the DSHS contract general provisions. All contractors must retain copies of the required assurances on file for review during program monitoring visits. Documents to support compliance with the assurances are to be kept on file with the Administrative Agency and at each respective subcontractor site, and will be reviewed by DSHS staff during site visits. Non-compliance with these Assurances could result in the suspension or termination of funding; therefore, it is imperative that the applicant read, understand, and comply with these *Assurances*.

G. POLICIES OF THE HIV/STD PREVENTION AND CARE AND TB/HIV/STD EPIDEMIOLOGY AND SURVEILLANCE BRANCHES

The contractor must abide by all relevant policies of the HIV/STD Prevention and Care Branch and the TB/HIV/STD Epidemiology and Surveillance Branch. Contractors are required to provide pertinent policies to its subcontractors, when applicable. Policies may be found at <http://www.dshs.state.tx.us/hivstd/policy/policies.shtm>. Contractors are encouraged to establish a policy manual to contain all DSHS policies.

H. FEDERAL RYAN WHITE POLICIES

Contractors and subcontractors are required to comply with HRSA's HIV/AIDS Bureau Policies for the Ryan White CARE Act. To this end, the DSHS recommends that all Administrative Agencies and their agents obtain and refer to the latest Ryan White Part B Manual. This manual can be downloaded at <http://www.hab.hrsa.gov/tools/title2/> or a hard copy can be requested by contacting the HRSA Information Center at (888) ASK HRSA.

I. PROGRAM REPORTING

1. Uniform Reporting System

Participation in the Uniform Reporting System (URS) is mandatory; currently, the URS system is the AIDS Regional Information and Evaluation System (ARIES). DSHS provides access to the URS at no cost to Administrative Agencies. Administrative Agencies are required to participate in the URS quality assurance activities. Administrative agencies must hire qualified personnel, as defined by DSHS policy, to fulfill the required duties and standards described in the policy. This includes assisting

providers in the collection and reporting of URS data and management, improvement and assistance in the application of URS data. **All Ryan White eligible services provided to Ryan White eligible clients must be reported by DSHS.**

2. HIV Services Program Quarterly Reports

Contractors are required to collect and maintain relevant data documenting the progress toward the goals and objectives of their project as well as any other data requested by the DSHS. **Contractors must demonstrate in the quarterly reports continuing efforts to assure that Ryan White monies are the payer of last resort through third party billing for all professional services, enrollment in available prescription plans and any other appropriate alternate payers.** All program reports are due in the format found on the DSHS HIV/STD web pages listed below no later than 20 days after the end of each reporting period, except for the 4th quarterly report. The progress toward meeting the program objectives must be reported for the quarter as well as year-to-date. All other reporting information is reported by quarter. The fourth quarter report will serve as the final program report. Failure to comply with deadlines and content requirements may result in an interruption of monthly reimbursements.

RW Administrative Agency, RW Service Delivery, and State Services providers use the same quarterly report format that is located at <http://www.dshs.state.tx.us/hivstd/fieldops/ReportsForms.shtm>.

Email all quarterly reports to:

- hivstdreport.tech@dshs.state.tx.us
and cc: (first.name.last.name@dshs.state.tx.us)
 - Your DSHS Services Consultant
 - Your DSHS Nurse Consultant
 - The DSHS ARIES Data Manager
 - The DSHS Quality Management Coordinator
 - Public Health Regional HIV Program Manager

If electronic submission is not an option, contact Linda Horton, Monitoring Manger, at (512) 458-7111 ext. 2189.

Due dates for the reporting periods are as follows:

1st Quarter (April 1 - June 30)	Due July 20
2nd Quarter (July 1 – September 30)	Due October 20
3rd quarter (October 1 - December 31)	Due January 20
4th quarter (January 1 - March 31)	Due May 30

3. Ryan White HIV/AIDS Program Data Report

The Ryan White HIV/AIDS Program Data Report (<http://hab.hrsa.gov/rdr/>) must be submitted each year by February 15 for services provided in the previous calendar year. Instructions on submission will be issued by DSHS. Entities that receive Ryan White Program funding from multiple parts are responsible for any additional registration that might be necessary to submit data due to their multiple sources of funding. .

J. FINANCIAL REPORTING

1. Quarterly Financial Status Reports

Financial status reports are required as provided in the UGMS and must be filed regardless of whether or not expenses were incurred. Quarterly Financial Status Reports (State of Texas Supplemental Form 269a/DSHS Form GC-4a), are required no

later than 30 days after the end of each quarter, except the fourth quarter. Due dates are set out in the project contract.

Required forms to use for these reports can be found at <http://www.dshs.state.tx.us/grants/forms.shtm>. Quarterly financial reports are to be mailed to the Department of State Health Services, Fiscal Division/Accounts Payable:

Claims Processing Unit, MC1940
Texas Department of State Health Services
1100 West 49th Street
PO Box 149347
Austin, TX 78714-9347

2. Final Report

A final Financial Status Report is required within 60 days following the end of the contract period. If necessary, a State of Texas Purchase Voucher is submitted by the Contractor if all costs have not been recovered or a refund will be made of excess monies if costs incurred were less than funds received. The final financial report is to be mailed to:

Claims Processing Unit, MC1940
Texas Department of State Health Services
1100 West 49th Street
PO Box 149347
Austin, TX 78714-9347

3. Equipment Inventory

Written prior approval for equipment purchases is required. Purchased equipment must be tagged and maintained on a property inventory. All equipment purchased with DSHS funds must be inventoried each year, no later than August 31st and reported to DSHS at cosequip@dshs.state.tx.us on DSHS Form GC-11 no later than October 15th. Equipment is defined as an item having a single unit cost of \$5,000 or greater and an estimated useful life of more than one year; however, personal computers, FAX machines, stereo systems, cameras, video recorder/players, microcomputers, and printers with a unit cost of over \$500 also are considered as equipment.

K. COLLABORATION WITH OTHER AGENCIES

The DSHS **requires** collaboration between administrative agencies, service providers and other HIV-related programs within the HIV Service Delivery Area (HSDA), including pediatric service demonstration projects; Ryan White Part A, B, C, D and F recipients; community, migrant, and homeless health centers; providers of HIV counseling and testing and prevention programs; the Texas HIV Medication Program (THMP); mental health and mental retardation providers; substance abuse facilities; STD clinical service providers; Federally Qualified Health Centers(FQHC); local and regional public health officials; federal HOPWA grantees; Section 8 Housing Authority; community groups; and, individuals with expertise in the delivery of HIV/AIDS services and knowledge of the needs of the target population. Formal linkages with DSHS contractors providing HIV counseling and testing services or comprehensive risk counseling services are also **required** to improve the integration of HIV prevention and care services. Formal linkages with hospital discharge planners are encouraged.

Since all newly diagnosed persons with HIV should be tested for TB and STDs, applicants must have a **formal** mechanism to refer clients for clinical services to provide

TB and STD screening and diagnosis, and treatment, as appropriate, from qualified medical providers and must ensure that such care is provided to clients who receive services under this grant. Applicants must also have a formal mechanism to refer all newly diagnosed persons with HIV disease for hepatitis testing and a process to refer for services, as appropriate.

AAs must make efforts to assure that Part B/State Services/HOPWA providers work with one another and with other providers as cooperative partners in providing a continuum of care for clients and in making successful referrals to one another. A lack of collaboration and cooperation with the DSHS on the part of any agency that receives DSHS funds will be considered grounds for sanctions up to and including termination of funds.

L. OUTREACH AND ACCESS TO SERVICES

Administrative Agencies must ensure that subcontractors are required to provide services that are equitably available and accessible to all HIV infected individuals needing services/care. Subcontractors must employ outreach methods to reach and provide services to eligible clients who may not otherwise be able to access the services, including difficult to reach and underserved populations. Subcontractors must provide for services so that hours of operation, availability of public transportation, and location do not create access barriers.

M. COMPREHENSIVE SERVICES PLAN and RESULTING ALLOCATIONS

Administrative Agencies are required to develop and annually update a Comprehensive Services Plan, which identifies needs, services, resource allocation and a plan to serve HIV infected and affected individuals within the designated administrative service area. A Comprehensive Services Plan includes the following components:

- An Executive Summary;
- Description of how the plan was developed and how community input and comment was included in the process;
- A Summary of HIV/AIDS epidemiology in the administrative service area;
- Summary of results of comprehensive assessment of needs for HIV medical and psychosocial support services, including client and providers assessments, an inventory of available resources to meet needs, and assessment of services gaps and unmet needs for HIV-related medical care;
- A brief summary of the continuum of care;
- Prioritization of Service Needs and Resource Allocation; and
- A Written Plan to Meet the Prioritized Service Needs; and
- One hundred percent (**100%**) of the Ryan White Service Delivery Part B and State Services contracts executed by the Administrative Agency are in compliance with the current Priorities and Allocations and the current Comprehensive Plan for HIV service delivery.

Needs for core medical services (outpatient/ambulatory medical services, AIDS pharmaceutical assistance (local), oral health care, early intervention services, health insurance premium and cost sharing assistance, home health care, home and community based health services, hospice services, mental health services, medical nutrition therapy, medical case management, substance abuse services – outpatient) are to be considered for use of Part B funds before other eligible categories of services. If no allocations are made to any of the above categories, the plan must specify how these services are to be delivered. All contracts executed by the AA using RWSD and SS

funds must reflect current priorities and allocations and the current Comprehensive Services Plan. The policy regarding requests to reallocate client services funds (Policy 241.006) may be found at www.dshs.state.tx.us/hivstd/policy/pdf/241006.pdf.

N. SUBCONTRACTING FOR HIV-RELATED SERVICES

Administrative Agencies are expected to enter into contracts with service providers and must ensure that contracts are in writing and are subject to the requirements of the primary contract. Administrative agencies and their contractors must recruit professional clinical services from a Medicaid/Medicare provider. If the contractor is unable to successfully recruit Medicaid/Medicare providers, then the administrative agency must demonstrate effort to recruit Medicaid approved professional services or present rationale for subcontracting to non-Medicaid/Medicare providers.

The Contractor must submit to DSHS all subcontractor information on the forms provided in the RWSD Application (Table 2 Subcontractor Data Sheet, Review Certification & Services Allocation and a Categorical Budget Justification or Subcontractor Fee for Service form*) 30 days from the contract begin date. Any additional subcontractors or changes to subcontractor information must be submitted to DSHS on the proper forms within 30 days of the addition or change. Email one original to: hiv-srvscontracts@dshs.state.tx.us and mail an additional copy to the Public Health Regional HIV Program Manager.

O. QUALITY MANAGEMENT (QM)

Quality management requirements may be found in Section IX of the AA review tool at www.dshs.state.tx.us/hivstd/fieldops/Page_02/AA_review_tool.doc

* If a subcontractor is adopting unit cost reimbursement, then both a categorical budget justification and a subcontractor fee for service form are required to be submitted.