U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

HIV/AIDS Bureau
Division of Metropolitan HIV/AIDS Programs

Ryan White Part A
HIV Emergency Relief Grant Program

Announcement Type: Competing Continuation
Announcement Number: HRSA-15-003

Catalog of Federal Domestic Assistance (CFDA) No. 93.914

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2015

Application Due Date: September 19, 2014

Modified on 8/28 to indicate that the Budget Narrative should be attached only to the Budget Narrative attachment form. Applicants do not need to attach the budget narrative as Attachment 12. Corrections have been made on pages 30 and 34 (in red, bold and underlined text).

Ensure SAM.gov Grants.gov registration and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration in all systems, including SAM.gov and Grants.gov,
may take up to one month to complete.

Release Date: July 7, 2014

Issuance Date: July 7, 2014

Steven R. Young, MSPH
Director, Division of Metropolitan HIV/AIDS Programs
Email: SYoung@hrsa.gov
Telephone: (301) 443-9091
Fax: (301) 443-5271

Authority: Public Health Service Act, Sections 2601-2610 (42 USC 300ff-11 – 300ff-20), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87)

EXECUTIVE SUMMARY

The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB)/Division of Metropolitan HIV/AIDS Programs is accepting applications for the fiscal year (FY) 2015 Ryan White Part A HIV Emergency Relief Grant Program. The purpose of this grant program is to: provide direct financial assistance to an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA) that has been severely affected by the HIV epidemic.

Funding Opportunity Title:	Ryan White Part A HIV Emergency Relief Grant Program
Funding Opportunity Number:	HRSA-15-003
Due Date for Applications:	September 19, 2014
Anticipated Total Annual Available Funding:	$618,492,359
Estimated Number and Type of Award(s):	52 grants
Estimated Award Amount:	Varies
Cost Sharing/Match Required:	No
Project Period:	3/1/2015-2/28/2016 (1 year)
Eligible Applicants:	Part A Grantees that are classified as an EMA or as a TGA and continue to meet the statutory requirements are eligible to apply for these funds. [See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]

All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide,* available online at http://www.hrsa.gov/grants/apply/applicationguide/sf424guide.pdf, except where instructed in this funding opportunity announcement to do otherwise. A short video for applicants explaining the new *Application Guides* is available at http://www.hrsa.gov/grants/apply/applicationguide/.

All applicants are encouraged to participate in a technical assistance (TA) webinar for this funding opportunity. The technical assistance webinar is tentatively scheduled for August 7, 2014 from 2-4PM Eastern Time. The purpose of this webinar is to assist potential applicants in preparing applications that address the requirements of this funding announcement. Participation in a pre-application TA webinar is optional.

Dial-in Phone Number: 1-800-857-6259
Passcode: 7527379
To access the webinar online, go to the Adobe Connect URL:
https://hrsa.connectsolutions.com/2015FOA/

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I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Ryan White Part A HIV Emergency Relief Grant Program. Part A funds provide direct financial assistance to an eligible metropolitan area (EMA) or a transitional grant area (TGA) that has been severely affected by the HIV epidemic. Grants assist eligible program areas in developing or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV through the provision of formula, supplemental, and Minority AIDS Initiative (MAI) funds. A comprehensive continuum of care includes the 13 core medical services specified in law, and appropriate support services that assist people living with HIV and AIDS (PLWH) in accessing treatment for HIV/AIDS infection that is consistent with the Department of Health and Human Services (HHS) Treatment Guidelines. (See http://www.aidsinfo.nih.gov). Comprehensive HIV/AIDS care beyond these core services may include supportive services that meet the criteria of enabling individuals and families living with HIV/AIDS to access and remain in primary medical care to improve their medical outcomes.

HRSA/HAB recognizes that Part A EMAs and TGAs must use grant funds to support and further develop and/or expand systems of care to meet the needs of PLWH within the EMA/TGA and strengthen strategies to reach minority populations. HAB has required EMAs/TGAs to collect data to support identification of need, for planning purposes, and to validate the use of Ryan White HIV/AIDS Program funding. A comprehensive application should reflect how those data were used to develop and expand the system of care in EMA/TGA jurisdictions. Grantees should review/reference relevant needs assessments conducted by other HIV/AIDS programs, such as HRSA's Bureau of Primary Health Care, Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and the U.S. Department of Housing Urban Development.

Ongoing CDC initiatives, as well as HAB's efforts with grantees to estimate and address Unmet Need of those aware of their HIV status and the newer requirement to identify and bring into care persons in their jurisdictions who are unaware of their positive HIV status, should result in many more PLWH entering into the EMA/TGA care system. The EMA/TGA planning process must ensure that essential core medical services have been adequately funded to meet the needs of those already in care and those being linked to care.

As of March 2014, the CDC estimates more than 1.1 million people are living with HIV and 1 in 5 people do not know their HIV status. The ultimate goal of the United States (U.S.) Public Health Service's (PHS) is to inform all HIV-positive persons of their status and bring them into care in order to improve their health status, prolong their lives, and slow the spread of the epidemic in the U.S. through enhanced prevention efforts. A list of CDC initiatives can be found at http://www.cdc.gov/hiv/topics/prev_prog/index.htm.

Important Notes:

- In accordance with the Ryan White HIV/AIDS Program legislation (Sec. 2603 (a)(4)) of the PHS Act hold harmless will not be a factor in the FY 2015 Ryan White Part A awards.
- Information on Ryan White and the Affordable Care Act, along with Policy Clarification Notices can be found at http://hab.hrsa.gov/affordablecareact/.

- The Early Identification of Individuals with HIV/AIDS (EIIHA) requirements in this funding announcement have been updated and streamlined. These requirements are included in section 2.B. of the Needs Assessment. Please review carefully when preparing this section of your application.

- Information on the National HIV/AIDS Strategy (NHAS) is located in the SF-424 Application Guide.

- Greater emphasis has been placed on the HIV Care Continuum. Applicants are expected to include a graph illustrating the HIV Care Continuum in the EMA/TGA and an explanation of how the Continuum is utilized in your jurisdiction at present or plans to integrate it into future use. **As this is a new section it will not be scored for the FY 15 FOA**. Refer to the Work Plan section for requirements.

The following information will assist in understanding and completing this year's grant application:

- Grantees are required to have implemented the Part A National Monitoring Standards at the grantee and provider/sub-recipient levels. HRSA has developed and distributed guidelines outlining the responsibilities of HRSA, the grantee, and provider staff. The National Monitoring Standards can be found at: http://hab.hrsa.gov/manageyourgrant/granteebasics.html.

- Women, Infants, Children and Youth (WICY) waiver requests are no longer part of the application process. The WICY waiver reporting format was revised to allow grantees to submit a waiver request and provide supporting data with the annual progress report.

- Part A funds are subject to Section 2604(c) of the PHS Act which requires that not less than 75 percent of the funds be used to provide core medical services that are needed in the EMA/TGA for individuals with HIV/AIDS who are identified and eligible under the Ryan White HIV/AIDS Program. Core medical services are listed in section 2604(c)(3) of the PHS Act, and support services allowed under Part A are limited to services that are needed for individuals with HIV/AIDS to achieve their medical outcomes, as defined by the Ryan White HIV/AIDS Program. The most recent service definitions can be found in the latest version of the National Monitoring Standards.

- Applicants seeking a waiver to the core medical services requirement must submit a waiver request either with this grant application, at any time up to the application submission, or up to 4 months after the start of the grant award for FY 2015. Submission should be in accordance with the information and criteria published by HRSA in the Federal Register Notice, Vol. 78, No. 101, dated Friday, May 24, 2013, and may be found at http://www.gpo.gov/fdsys/pkg/FR- 2013-05-24/pdf/2013-12354.pdf. Sample letters may be found at http://hab.hrsa.gov/affordablecareact/samplereqwaiverletters.pdf. In addition, grantees are advised that a FY 2015 Part A waiver request must include funds awarded under the Minority AIDS Initiative (MAI). A waiver request that does not include MAI will not be considered. If submitting with the application, a core medical services waiver request should be included as **Attachment 8**.

- EMA/TGA Agreements and Compliance Assurances are included (**Appendix A**) with this funding opportunity announcement (FOA), and require the signature of the CEO, or the CEO's designee; this document should be included as **Attachment 2**.

2. Background

This program is authorized by the Public Health Service Act, Sections 2601-2610 (42 USC 300ff-11– 300ff-20), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 11-87), (hereafter referred to as the Ryan White HIV/AIDS Program). Part A grants to EMAs and TGAs include formula and supplemental components, as well as MAI funds which support services targeting minority populations. Formula grants are based on living HIV/AIDS cases, as of December 31, in the most recent calendar year for which data are available, as reported to and confirmed by the CDC. Therefore, applicants are required to report on the number of persons living with HIV and AIDS in their jurisdictions. Supplemental grants are awarded competitively on the basis of demonstrated need and other criteria. MAI funding is awarded using a formula that is based on the distribution of living HIV/AIDS cases among racial and ethnic minorities. In each EMA, local planning councils (PC) set priorities and allocate Part A funds on the basis of the size, demographics, and needs of the population living with or affected by HIV. TGAs are required to use a community planning process. While the use of PCs is optional pending further direction from statutory provisions, and/or appropriations language, TGAs that have currently operating PCs are strongly encouraged to maintain that structure. Applicants are reminded that MAI funds should be fully integrated into Part A planning, priority setting and allocation processes. The legislation can be obtained at: http://www.gpo.gov/fdsys/pkg/USCODE-2011-title42/html/USCODE-2011-title42-chap6A-subchapXXIV.htm.

Affordable Care Act (ACA)
As part of the Affordable Care Act (ACA), the health care law enacted in 2010, several significant changes have been made in the health insurance market that expand options for health care coverage, including those options for people living with HIV/AIDS. The ACA creates new state-based marketplaces, also known as exchanges, to offer millions of Americans access to affordable health insurance coverage. Under the ACA individuals with incomes between 100 to 400 percent 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 participate, Medicaid eligibility expands to non-disabled adults with incomes of up to 133 percent of FPL 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 affordable and accessible for Americans. These health care coverage options may be reviewed at http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf.

Outreach efforts are needed to ensure that families and communities understand these new health care coverage options and to provide eligible individuals assistance to secure and retain coverage. The HIV/AIDS Bureau recognizes that outreach to and enrollment of Ryan White HIV/AIDS Program (RWHAP) clients into the expanded health insurance coverage is critical. As appropriate and allowable by statute, RWHAP grantees are strongly encouraged to support ACA-related outreach and enrollment activities to ensure that clients fully benefit from the new

health care coverage opportunities. For more information on allowable outreach and enrollment activities, please see http://www.hab.hrsa.gov/affordablecareact/outreachenrollment.html.

Applicants are expected to include a description of plans for outreach and enrollment of RWHAP clients into new health coverage options. Current grantees should describe how they will help their clients take advantage of new health coverage opportunities. Grantees and sub-grantees should also assure that individual clients are enrolled in any appropriate health care coverage whenever possible or applicable, and informed about the financial or coverage consequences if they choose not to enroll.

For more information on the marketplaces and the health care law, visit http://www.healthcare.gov.

HIV Care Continuum

Identifying people infected with HIV and linking them to HIV primary care with initiation and long-term maintenance of life-saving antiretroviral treatment (ART), are important public health steps toward the elimination of HIV in the United States. The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the HIV Care Continuum or the Care Treatment Cascade. The HIV Care Continuum includes the diagnosis of HIV, linkage to HIV medical care, lifelong retention in HIV medical care, appropriate prescription of ART, and ultimately HIV viral load suppression.

The difficult challenge of executing these lifesaving steps is demonstrated by the data from the CDC, which estimate that only 25 percent of individuals living with HIV in the United States have complete HIV viral suppression. Data from the Ryan White Service Report (RSR) indicate that there are better outcomes in Ryan White HIV/AIDS Program (RWHAP) funded agencies with approximately 70% of individuals who received RHWAP-funded medical care being virally suppressed. Such findings underscore the importance of supporting effective interventions for linking HIV-positive individuals into care, retaining them in care, and helping them adhere to their combination antiretroviral regimens.

RWHAP grantees are encouraged to assess the outcomes of their programs along this continuum of care. Grantees should work with their community and public health partners to improve outcomes across the Continuum of HIV Care, so that individuals diagnosed with HIV are linked and engaged in care and started on ART as early as possible. HAB has worked with other agencies within the Department of Health and Human Services (HHS) to develop performance measures to assist in assessing outcomes along the continuum. HAB encourages grantees to use these performance measures at their local level to assess the efficacy of their programs and to analyze and address the gaps along the HIV Care Continuum to improve the care outcomes provided. These efforts are in alignment with the support and goals and objectives of the National HIV/AIDS Strategy.

The HIV Care Continuum measures also align with the HHS Common HIV Core Indicators approved by the before Secretary and announced in August 2012. RWHAP grantees and providers are required to submit data through the Ryan White Services Report (RSR). Through the RSR submission, HAB currently collects the data elements to produce the HHS Common HIV Core Indicators. HAB will calculate the HHS Core Indicators for the entire RWHAP. HAB will use these data to report six of the seven HHS Common HIV Core Indicators to the Department of Health and Human Services, Office of the Secretary for Health.

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding during Federal fiscal year 2015. Approximately $618,492,359 is expected to be available to fund fifty-two (52) grantees. The actual amount available will not be determined until enactment of the final FY 2015 Federal budget. This program announcement is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed, and funds can be awarded in a timely manner. The project period is one (1) year. Supplemental funding for Part A is available on a competitive grant application basis to EMAs/TGAs whose applications address the following legislative criteria:

- **a)** contains a report concerning the dissemination of the Part A formula funds, and the plan for utilization of such funds;
- **b)** demonstrates need in the area, on an objective and quantified basis for supplemental financial assistance to combat the HIV epidemic;
- **c)** demonstrates the existing commitment of local resources of the area, financial and in-kind to combating the HIV epidemic;
- **d)** demonstrates the ability of the area to utilize such supplemental financial resources in a manner that is immediately responsive and cost effective;
- **e)** demonstrates that resources will be allocated in accordance with the local demographic incidence of AIDS, including appropriate allocations for services for women, infants, children, youth (WICY), and families with HIV/AIDS;
- **f)** demonstrates the inclusiveness of affected communities and individuals living with HIV and AIDS;
- **g)** demonstrates the manner in which the proposed services are consistent with the local needs assessment and the Statewide Coordinated Statement of Need;
- **h)** demonstrates the ability of the applicant to expend funds efficiently by not having had, for the most recent Part A formula grant year, for which data is available, more than five percent of grant funds unobligated at the end of the year, even if a request for carryover was granted; and
- **i)** demonstrates success in identifying individuals living with HIV and AIDS who are unaware of their HIV/AIDS status, and provides a description of the strategy, plan, and data associated with the early identification of these individuals.

III. Eligibility Information

1. Eligible Applicants

Part A Grantees who are classified as an EMA or as a TGA, and continue to meet the statutory requirements are eligible to apply for these funds. For an EMA, this is more than 2,000 cases of

AIDS reported and confirmed during the most recent 5 calendar years, and for a TGA, this is at least 1,000, but fewer than 2,000 cases of AIDS reported and confirmed during the most recent period of 5 calendar years for which such data are available. Additionally, for three consecutive years, grantees must not have fallen below the required incidence levels already specified, and required prevalence levels (cumulative total of living cases of AIDS reported to and confirmed by the Director of the CDC, as of December 31 of the most recent calendar year for which such data are available); for an EMA, this is 3,000 living cases of AIDS, and for a TGA, this is 1,500 living cases of AIDS, or at least 1,400 (and fewer than 1,500) living cases, as long as the area did not have more than 5 percent of the total amount from grants awarded to the area under this part unobligated, as of the end of the most recent fiscal year.

2. Cost Sharing/Matching

Cost sharing/matching is not required for this program.

3. Other

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization are not allowable.

Maintenance of Effort (MOE)
The Ryan White HIV/AIDS Program legislation requires Part A Grantees to maintain, as a Condition of Award, EMA/TGA political subdivision expenditures for HIV-related core medical services and support services at a level equal to the 1-year period preceding the FY for which the grantee is applying to receive a Part A grant. After enactment of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Section 2604(b)(1) of the PHS Act states: “In general – The chief elected official of an eligible area shall use amounts from a grant under Section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services.” Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation and the HIV/AIDS Bureau service definitions distributed to all grantees. Part A Grantees must document they have met the maintenance of effort (MOE) requirement.

To demonstrate that grantees understand this revision to the Part A MOE requirement, applicants must submit the following information:

- **a)** A table that identifies the MOE budget elements and the amount of expenditures related to core medical services and support services for FYs 2012 and 2013, and;
- **b)** A description of the process used to determine the amount of expenditures reported in the table.

This requirement is included as part of the Organizational Information section of this FOA.

IV. Application and Submission Information

1. Address to Request Application Package

HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov. Applicants must download the SF-424 application package associated with this funding opportunity following the directions provided at Grants.gov.

2. Content and Form of Application Submission

Section 4 of HRSA's *SF-424 Application Guide* provides instructions for the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract. You must submit the information outlined in the Application Guide in addition to the program specific information below. All applicants are responsible for reading and complying with the instructions included in HRSA's *SF-424 Application Guide* except where instructed in the funding opportunity announcement to do otherwise.

Application Page Limit
The total size of all uploaded files may not exceed the equivalent of 100 pages when printed by HRSA. The page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support required in the *Application Guide* and this FOA. Standard OMB-approved forms that are included in the application package are NOT included in the page limit. Indirect Cost Rate Agreement and proof of non-profit status (if applicable) will not be counted in the page limit. **We strongly urge you to print your application to ensure it does not exceed the specified page limit.**

Applications must be complete, within the specified page limit, and validated by Grants.gov under the correct funding opportunity number prior to the deadline to be considered under the announcement.

Program-Specific Instructions
In addition to application requirements and instructions in Section 4 of HRSA's *SF-424 Application Guide* (including the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract), please include the following:

i. Project Abstract
See Section 4.1.ix of HRSA's *SF-424 Application Guide*. In addition to the instructions in section 4.1.ix of HRSA's *SF-424 Application Guide,* please include a project abstract, with the following information in this order:

a) general demographics of EMA/TGA;
b) demographics of HIV/AIDS populations in the EMA/TGA;
c) geography of the EMA/TGA with regard to communities affected by HIV/AIDS and the location of HIV/AIDS services in relation to those communities, including minority populations served with Minority AIDS Initiative (MAI) funds;
d) description of the continuum of care offered in the EMA/TGA, including relevant information about the primary medical care services, how HIV primary care services are delivered, and how clients are supported in accessing and remaining in care; and

e) number of years the EMA/TGA has received Part A and MAI funding.

ii. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Use the following section headers for the Narrative:

- *INTRODUCTION -- Corresponds to Section V's Review Criterion #1*
  This section should briefly describe how the EMA or TGA will utilize RWHAP Part A grant funds in support of a comprehensive continuum of high-quality care and treatment for people living with HIV/AIDS in the Part A service area.

- *NEEDS ASSESSMENT -- Corresponds to Section V's Review Criterion #1*
  The purpose of this section is to demonstrate the severity of the HIV/AIDS epidemic in the EMA/TGA, using quantifiable data on HIV epidemiology, co-morbidities, cost of care for Ryan White HIV/AIDS Program services, the service needs of emerging populations, Unmet Need for services, and unique service delivery challenges. This section should explain why supplemental funding for health services is needed to provide necessary services for PLWH in the EMA/TGA.

  Note: *When describing Need, applicants should* ***document the use of multiple data sets****, such as HIV/AIDS epidemiologic data, co-morbidity data, poverty and insurance status data, current utilization data, and assessments of emerging populations with special needs. All data sources must be cited.*

1. **Jurisdictional Profile**
   When made available for funding, supplemental funds will be targeted to those eligible areas where epidemiologic data demonstrates that HIV disease prevalence rates are increasing, where there is documented Unmet Need, and where there is a demonstrated disproportionate impact on vulnerable populations.

   (1) Use a table to describe the EMA/TGA incidence and prevalence of HIV and AIDS for the past 3 calendar years (2011, 2012, and 2013). Clearly cite the data sources.

   (2) Use a table to provide HIV/AIDS cases by demographic characteristics (age, ethnicity, race, and gender) and exposure category in the EMA/TGA for the past 3 calendar years (2011, 2012, and 2013); if data for this 3 year period is unavailable, use data from the most current 3 year period and provide an explanation. Submit as **Attachment 3**.

   (3) Provide a brief narrative description of the following:
   a. Disproportionate impact of HIV/AIDS on specific populations within the EMA/TGA in comparison to the impact on the general population, including disproportionately impacted minority communities, homeless, and formerly-incarcerated individuals living with HIV/AIDS;

b. Populations of PLWH in the EMA/TGA that are under-represented in the Ryan White HIV/AIDS Program funded system of HIV/AIDS primary medical care; and

c. New/emerging populations not reported on in last year's application where significant changes were noted in service delivery in the EMA/TGA. Include information on how emerging populations were identified, unique challenges, service gaps, and estimated costs to the Part A Program, (if applicable).

2. Demonstrated Need

Supplemental awards are to be directed principally to those eligible areas with the greatest demonstrated need, based on documented factors that are comparable across the EMA/TGAs. In order to target funding to these areas, demonstrated need is given greater weight in the scoring process. The FY 2015 plan, budget, and allocations table should be consistent with the discussion of demonstrated need. The Demonstrated Need section includes: Unmet Need, Early Identification of Individuals with HIV/AIDS (EIIHA), Unique Service Delivery Challenges, Minority AIDS Initiative (MAI), and Impact of Funding.

A. Unmet Need

Unmet Need for Health Services, also referred to as Unmet Need, is the need for HIV related Health Services by individuals with HIV who are aware of their HIV status, but are not receiving regular primary health care.

(1) Provide an updated estimate of Unmet Need in your jurisdiction, using the HRSA/HAB Unmet Need Framework and calendar year (CY) 2013 data; include a copy of the framework in **Attachment 4** of this application.

(2) Provide a table showing the percentage of Unmet Need for PLWA and PLWH for CY 2011, 2012, and 2013. Based on this table, describe the trends in your Unmet Need percentages and to what you attribute these changes (e.g. increased outreach, increased linkages to care, increased number of low income PLWH).

(3) Describe how these Unmet Need trends are reflected in planning and decision making. Provide a narrative description of the following:
   a. Determination of the demographics and location of people who know their HIV/AIDS status and who are not in care. Use geographic mapping such as zip code or geo-mapping data, if available.
   b. Describe the method used to assess service needs, gaps, and barriers to care for people not in care; note the date of the latest needs assessment.
   c. Describe efforts to assist the people who know their status and who are not in care in accessing primary care; specifically how the results of the Unmet Need Framework are reflected in the planning and decision making process about priorities, resource allocations, and the system of care. Examples include: (1) outreach activities, and (2) collaboration with other Ryan White and non-Ryan White HIV/AIDS Program funded providers.

B. Early Identification of Individuals with HIV/AIDS (EIIHA)

The purpose of this section is to describe the strategy, plan, and data associated with ensuring that individuals who are unaware of their HIV status are identified, informed of their status, referred to supportive services, and linked to medical care if HIV positive. 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, and 3) increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative.

***Use of RWHAP funds for HIV testing*:**

RWHAP funds for testing under Early Invention Services (EIS) for Part A, Sections 2604(c)(3)(E) and 2604 (e)(1-2) of the PHS Act, can be used to include identification of individuals at points of entry and access to services and provision of:

a. HIV testing and targeted counseling;
b. Referral services;
c. Linkage to care; and
d. Health education and literacy training that enable clients to navigate the HIV system of care.

Note: *All four EIS components must be present, but Part A funds to be used for HIV testing can be used only as necessary to supplement, not supplant existing funding for HIV testing, including routine testing, in the jurisdiction.*

(1) EIIHA Data

Select **three** (3) target populations in the previously submitted FY 2014 EIIHA Plan. For the selected three target populations, provide the following data for January 1, 2014 – June 30, 2014:

Newly diagnosed positive HIV test events:

a. Number of test events
   - *HIV testing event*

   An HIV testing event is a sequence of one or more HIV tests conducted with the client to determine his or her HIV status. During a single testing event, a client may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one conventional test to confirm a preliminary HIV-positive test result).

b. Number of newly diagnosed positive test events
   - *Newly identified HIV-positive result*

   An HIV-positive test result associated with a client who does not self-report having previously tested HIV positive and has not been reported to jurisdiction's surveillance department as being HIV positive.

c. Number of newly diagnosed positive test events with client linked to HIV medical care

- *Linkage to HIV medical care*

  This calculated indicator determines whether a client with an HIV-positive test result was linked to HIV medical care within 90 days of initial positive test. In order for a client to be linked to care, the client must both be referred to HIV medical care and attend the first medical care appointment.

- *HIV medical care*

  HIV medical care includes medical services for HIV infection including evaluation of immune system function and screening, treatment and prevention of opportunistic infections.

d. Number of newly diagnosed confirmed positive test events

- *Newly identified confirmed HIV-positive result*

  A confirmed HIV-positive test result associated with a client who does not self-report having previously tested HIV positive and who has not been reported to jurisdiction's surveillance department as being HIV positive.

- *Confirmed HIV-positive result*

  A testing event with a positive test result for a conventional HIV test (positive EIA test confirmed by supplemental testing, e.g., Western Blot) or a nucleic acid amplification test (NAAT).

e. Number of newly diagnosed confirmed positive test events with client interviewed for partner services

- *Referral to partner services*

  This calculated indicator determines whether a client with a confirmed HIV-positive test result was given a referral to partner services.

- *Interviewed for partner services*

  This calculated indictor determines whether a client with a confirmed HIV-positive test result was interviewed for partner services within 30 days of receiving a confirmed positive test result. In order for a client to be counted as <u>interviewed</u> for partner services, the client must both be <u>referred</u> to partner services and <u>interviewed</u> within 30 days of a positive test result.

f. Number of newly diagnosed confirmed positive test events with client referred to prevention services

- *Referral to prevention services*

  This indicator determines whether a client with confirmed HIV-positive test results was given a referral to HIV prevention services.

g. Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing

- *CD4/VL*

  This variable indicates whether a client with confirmed HIV-positive test results received CD4 and VL testing.

Previously diagnosed positive HIV test events:

a. Number of test events
   - *HIV testing event*

   An HIV testing event is a sequence of one or more HIV tests conducted with the client to determine his or her HIV status. During a single testing event, a client may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one conventional test to confirm a preliminary HIV-positive test result).

b. Number of previously diagnosed positive test events
   - *Previously identified HIV-positive result*

   An HIV-positive test result associated with a client who self-reports having previously tested HIV positive, or has been reported to jurisdiction's surveillance department as being HIV positive

c. Number of previously diagnosed positive test events with client re-engaged in HIV medical care
   - *Linkage to HIV medical care*

   This calculated indictor determines whether a client was linked to HIV medical care within 90 days of the re-diagnosis. In order for a client to be linked to care, the client must both be referred to HIV medical care and attend the first medical care appointment.

   - *HIV medical care*

   HIV medical care includes medical services for HIV infection including evaluation of immune system function and screening, treatment and prevention of opportunistic infections.

d. Number of previously diagnosed confirmed positive test events
   - *HIV testing event*

   An HIV testing event is a sequence of one or more HIV tests conducted with the client to determine his or her HIV status. During a single testing event, a client may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one conventional test to confirm a preliminary HIV-positive test result).

   - *Confirmed HIV-positive result*

   A testing event with a positive test result for a conventional HIV test (positive EIA test confirmed by supplemental testing, e.g., Western Blot) or a nucleic acid amplification test (NAAT).

e. Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services
   - *Referral to partner services*

   This calculated indicator determines whether a client with a confirmed HIV-positive test result was given a referral to partner services.

- *Interviewed for partner services*

This calculated indictor determines whether a client with a confirmed HIV-positive test result was interviewed for Partner Services within 30 days of receiving their confirmed positive test result. In order for a client to be counted as interviewed for Partner Services, the client must both be referred to Partner Services and interviewed within 30 days of positive test result.

f. Number of previously diagnosed confirmed positive test events with client referred to prevention services

- *Referral to prevention services*

This indicator determines whether a client with confirmed HIV-positive test results was given a referral to HIV prevention services.

g. Number of previously diagnosed confirmed positive test events linked to and accessed CD4 cell count and viral load testing

- *CD4/VL*

This variable indicates whether a client with confirmed HIV-positive test results received CD4 and VL testing.

(2) **FY15 EIIHA Plan**

The overarching goal of the EIIHA Plan is to reduce the number of undiagnosed and late diagnosed individuals and to ensure they are accessing HIV care and treatment.

a. Describe the planned activities of the EMA/TGA EIIHA Plan for FY 2015. Include the following information:
   - An updated estimate of individuals who are HIV positive and who are unaware of their status, including the estimate methodology;
   - All populations for the EIIHA Plan;
   - The primary activities that will be undertaken, including system level interventions e.g. routine testing in clinical settings, expanding partner services;
   - Major collaborations with other programs and agencies, including HIV prevention- and surveillance programs; and
   - The planned outcomes of your overall EIIHA strategy.

b. Describe how the overall FY 2015 EIIHA Plan contributes to the goals of the National HIV/AIDS Strategy and the White House Continuum of Care Initiative. The Executive Order on the HIV Care Continuum Initiative that was released on July 15, 2013, is available at http://www.whitehouse.gov/the-press-office/2013/07/15/executive-order- hiv-care-continuum-initiative.

c. Describe how the Unmet Need estimate and activities related to the Unmet Need population inform and relate to the EIIHA planned activities.

d. Describe how the EIIHA Plan for FY 2014 (e.g. process, activities

and outcomes) influenced the development of the EIIHA Plan for FY 2015.

e. Describe any planned efforts to remove legal barriers, including state laws and regulations, to routine HIV testing.

f. Select three (3) distinct target populations for the FY 2015 EIIHA Plan. For each selected target population describe:
   - Why the target population was chosen and how the epidemiological data, Unmet Need estimate data, or other data supports that decision;
   - Specific challenges with or opportunities for working with the targeted population;
   - The specific activities that will be utilized with the target population;
   - Specific objectives for each component of EIIHA (identify, inform, refer, and link to care) for the target population (all objectives should be written as S.M.A.R.T. objectives – **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime phased);
   - The responsible parties, including any coordination with other agencies and/or programs for ensuring each of the activities are implemented, and their respective roles; and
   - Planned outcomes that will be achieved for the target population as a result of implementing the EIIHA Plan activities.

g. Describe plans to present, discuss, and/or disseminate the EIIHA Plan and outcomes of your EIIHA Plan activities to stakeholders (e.g. poster presentations, journal articles, presentations to planning bodies).

C. Unique Service Delivery Challenges

If applicable provide a brief narrative description of the need for HIV/AIDS emergency grant funds in the EMA/TGA based on factors not already discussed in the preceding demonstrated need narratives. The narrative should describe any unique service delivery challenges specific to the EMA/TGA Ryan White HIV/AIDS Program funded services, in terms of service costs, changes in service providers, and the complexity of providing care as a result of these challenges.

D. Minority AIDS Initiative

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by the epidemic.

The purpose of the Part A MAI is to improve "HIV-related health outcomes to reduce existing racial and ethnic health disparities." As such, MAI funds provide direct financial assistance to Part A Grantees to develop or enhance access to high quality, community-based HIV/AIDS care services, and improve health outcomes for low-income minority individuals and families. For purposes of this FOA, 'minority' is defined as an individual who self-identifies as a member of one of the

racial/ethnic communities, including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders, or as 'more-than-one-race.' Any new/emerging minority populations, identified in the Jurisdictional Profile, should be targeted with MAI funds.

(1) Identify minority populations based on epidemiological data for your jurisdiction and the specific sub-groups (i.e. young African-American and Latino MSM; minority women receiving services at family planning clinics; substance users; and persons living with HIV who are leaving correctional facilities and re-entering communities; etc.) targeted with MAI funds.

(2) Describe how MAI funding was considered during the planning process and what service categories were funded to enhance access to services for disproportionately impacted minority populations and sub-groups; explain how these services differ from other Part A services.

(3) Briefly describe up to two (2) MAI funded activities used to serve minority sub-groups in an effort to reduce barriers and enhance the effectiveness of HIV services provided to specific minority populations. Describe the impact of these activities as they relate to the HIV continuum of care (i.e. linkage to care, retention in care and viral load suppression).

3. Impact of Funding

The purpose of this section is to describe the impact of Part A funding and how service and funding mechanisms are coordinated in the EMA/TGA.

A. Impact of the Affordable Care Act

Through the Affordable Care Act, insurance coverage options have been expanded for PLWH. These changes may affect insurance coverage options in the jurisdiction, as well as service needs and how those services are provided. In addition, these new options may require specific outreach and enrollment activities to ensure that people eligible for coverage are expeditiously enrolled in any coverage for which they may qualify.

(1) **Uninsured and poverty:** Provide, in a table format, data on PLWH who are uninsured and living in poverty. Include the following information as available:

a. The number and percentage of persons who are enrolled in Medicaid, Medicare, and marketplace exchanges;
b. The number and percentage of persons without insurance coverage; include those without Medicaid or Medicare; and
c. The number and percentage of persons living at or below 138 percent and 400 percent of the 2014 FPL. Also include the percentage of FPL used to determine Ryan White eligibility in your jurisdiction.

(2) **Impact of insurance expansion:** Describe the impact of the Affordable Care Act and insurance expansion on the Part A RWHAP. Describe how the implementation of the Affordable Care Act impacts both service costs and the complexity of providing care to PLWH in the EMA/TGA. Describe any changes in service or allocations, including activities related to health insurance

premium assistance and cost sharing, either on a local level or in conjunction with the state.

(3) **Outreach and enrollment:** Describe efforts within the jurisdiction to conduct outreach to clients regarding insurance coverage options and to vigorously pursue enrollment of Part A clients into insurance coverage for which they may be eligible (e.g., Medicaid, private health insurance, etc.), as outlined in HAB Policy Clarification Notices 13-01 and 13-04 (http://hab.hrsa.gov/manageyourgrant/policiesletters.html). Describe coordination efforts with other agencies and community partners.

(4) **Marketplace options:** Provide an overall description of the plans available to PLWH and specify how they relate to the issue of provider accessibility and medications. Explain any challenges PLWH are experiencing or may experience in accessing care and medications.

(5) **Successes/Outcomes:** Please document any successes/case studies and/or outcomes in terms of cost-savings, service provision, and meaningful outcomes.

B. Impact and Response to Reduction in Ryan White HIV/AIDS Program Formula Funding

If the EMA/TGA experienced a reduction in Ryan White HIV/AIDS Program Part A Formula Funding last year, provide a narrative that addresses both the impact and response to the funding reduction, as follows:

(1) Impact: The specific services that were eliminated or reduced, and by how much; and

(2) Response: Any cost containment measures implemented, (e.g. waiting lists, client cost sharing, or other measures); planning council or community planning body response to the reduction in formula funding; and any transitional planning for clients receiving services that were either eliminated or reduced.

C. Impact of Co-morbidities on the Cost and Complexity of Providing Care

Ryan White HIV/AIDS Program funds are intended to supplement funding for local healthcare systems overburdened by the increasing cost of providing healthcare services. In addition to HIV/AIDS, public healthcare systems must address a variety of co-morbidities that may increase the cost of delivering care to persons living with HIV/AIDS. Caring for large numbers of PLWH clients with multiple diagnoses also adds to the cost and complexity of care.

(1) Present the profile of PLWH with co-morbidities in the EMA/TGA using quantitative evidence (in table format in **Attachment 5**) and document data sources. **The table must include:**

a. STI rates;
b. Prevalence of homelessness;
c. Formerly incarcerated;
d. Mental illness; and

e. Substance abuse

(2) Support the quantitative data presented in the table (**Attachment 5**), with a narrative description of the impact of co-morbidities, and co-factors on the cost and complexity of care in the EMA/TGA.

D. Coordination of Services and Funding Streams

Part A EMA/TGA planning efforts should expand the availability of services, reduce duplication of services, and bring newly diagnosed PLWH into care or engage PLWH who know their status, but are not presently in the HIV/AIDS care system. Planning should also be coordinated with all other public funding for HIV/AIDS to: (1) ensure that Ryan White HIV/AIDS Program funds are the payer of last resort, (2) maximize the number and accessibility of services available, and (3) reduce any duplication.

(1) Provide in table format as **Attachment 6,** a presentation of other public funding in the EMA/TGA. The table should include the dollar amount(s) and the percentage of the total available funds in 2014, and the anticipated funds in 2015 for the following:

a. Other Ryan White HIV/AIDS Program funding (Parts B, C, D, and F);
b. Federal/state and local sources of public funding; and
c. HIV/AIDS-related service funds available in FY 2014 and anticipated in FY 2015.

(2) Based on the table in **Attachment 6**, discuss how Part A funds are used to address any gaps in services within the jurisdiction.

- *METHODOLOGY -- Corresponds to Section V's Review Criterion #2*

1. Planning and Resource Allocation

The purpose of this section is to document the existence of a functioning planning process in the EMA/TGA that is consistent with Ryan White HIV/AIDS Program and HRSA/HAB Program requirements. Good planning is imperative for effective local and state decision making to develop systems of prevention and care that are responsive to the needs of persons at risk for HIV infection and people living with HIV. Activities to collaborate and/or develop a joint planning body are supported by both HRSA and CDC. Community involvement is an essential component for planning comprehensive, effective HIV prevention and care programs in the United States. Please refer to the joint HRSA/CDC letter dated February 24, 2014 for more information on integrated planning.

The composition of the planning council (PC) or planning body must reflect the demographics of the HIV/AIDS epidemic in the EMA/TGA. PC or planning body members must be trained regarding their legislatively mandated responsibilities and other competencies necessary for full participation in collaborative decision-making. As part of their ongoing training, planning councils are encouraged to educate members about service issues related to the prevention of domestic and sexual violence. Councils should also consider recruiting members who are knowledgeable about these issues.

A. **Letter of Assurance from Planning Council Chair(s) or Letter of Concurrence from Planning Bodies**

Provide a letter of assurance signed by the PC chair(s) or a letter of concurrence signed by planning body leadership as **Attachment 7**. The letter must address the following:

(1) That FY 2014 Formula, Supplemental, and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the PC or planning body;
(2) That all FY 2014 Conditions of Award relative to the PC or planning body have been addressed;
(3) That FY 2014 priorities were determined by the PC or planning body, and the approved process for establishing those priorities were used by the PC or planning body;
(4) That annual membership training took place, including the date(s); and
(5) That representation is reflective of the epidemic in the EMA/TGA. If there are any vacancies, provide a plan and timeline for addressing each vacancy. Note variations between the demographics of the non-aligned consumers and the HIV disease prevalence of the EMA/TGA.

B. **Description of the Community Input Process**

(1) Describe the over-all structure of your community input process; include a description of the priority setting and allocations process, an explanation of how planning is linked or may be linked in the future to health outcomes along the HIV Care Continuum.

(2) Describe the specific prioritization and allocation process and include the following:
   a. How the needs of the following were considered: persons not in care (Unmet Need), persons unaware of their HIV status (EIIHA); and historically underserved populations;
   b. How PLWH were involved in the planning and allocation processes and how their priorities were considered in the process;
   c. How data were used in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the EMA/TGA;
   d. How changes and trends in HIV/AIDS epidemiology data were used in the planning and allocation process;
   e. How cost data were used in making funding allocation decisions;
   f. How the community input process considered and addressed any funding increases or decreases in the Part A award;
   g. How MAI funding was considered during the planning process to enhance services to minority populations;
   h. How data from other federally funded HIV/AIDS programs were used in developing priorities **(Attachment 6)**;
   i. How anticipated changes, due to the Affordable Care Act, were considered in developing priorities;
   j. What efforts have or will be taken to integrate prevention and care planning at the Part A level.

C. **Funding for Core Medical Services**

Part A funds are subject to Section 2604(c) of the PHS Act which requires that grantees expend 75 percent of Part A funds on core medical services that are needed in the EMA/TGA for individuals with HIV/AIDS who are identified and eligible under the Ryan White HIV/AIDS Program.

All applicants are required to submit a table that lists planned services for FY 2015 that addresses the 75 percent core medical services allocation requirement, regardless of whether the applicant intends to apply for a Core Medical Services (CMS) Waiver. In addition, applicants must provide a table that is reflective of the results of the priority setting and resource allocation process, if those results are different from the table reflecting compliance with the 75 percent core medical services allocation requirement. For applicants who were granted a FY 15 CMS waiver prior to this application, submit the approved allocations table. (The Planned Services Table and the Core Medical Services Waiver request, if applicable, should be included as **Attachment 8.)**

- *WORK PLAN -- Corresponds to Section V's Review Criterion #2*

The purpose of this section is to provide a graphic depiction and narrative summary describing the EMA/TGA HIV Care Continuum during FY 2015. It should describe how Part A funded services are utilized to impact the HIV Care Continuum. The EMA/TGA system of HIV/AIDS care should be consistent with HRSA's goals of increasing access to services and decreasing HIV/AIDS health disparities among affected sub-populations and historically under-served communities. Consideration regarding how and to what extent the HIV Care Continuum has been or will be used will not be subject to scoring during objective review.

A. **HIV Care Continuum for FY 2015**

The Executive Order on the HIV Care Continuum Initiative that was released on July 15, 2013, is available at http://www.whitehouse.gov/the-press-office/2013/07/15/executive-order- hiv-care-continuum-initiative.

(1) Provide a graph which depicts RWHAP Part A HIV Care Continuum in the EMA/TGA. The HIV Care Continuum also referred to as the HIV Treatment Cascade is a model of the proportion of PLWHs who are engaged at each stage of HIV care - Diagnosed, Linked to Care, Retained in Care, Prescribed ART, and Virally Suppressed. The graph must include baseline data for calendar year 2013 or the most recent calendar year for each stage of the HIV Care Continuum. At a minimum programs should use their RSR data as a baseline to populate the continuum for Ryan White-eligible individuals. If programs have access to a greater pool of data, it is strongly encouraged that it be used in the continuum. Applicants must clearly explain their data set and what data sources are being utilized. To populate the beginning of the continuum, the Diagnosed and Linked to Care stages, at a minimum applicants should use their EIIHA data. This data may also be obtained from local or state prevention programs. Another source for the data is the CDC's *Data to Care: A Public Health Strategy Using HIV Surveillance Data to Support the HIV Care Continuum*. *Data to Care* is a toolkit designed to share information and

resources to assist health departments in developing and implementing a *Data to Care* program. The toolkit can be accessed at http://www.effectiveinterventions.org/en/HighImpactPrevention/PublicHealthStrategies/DatatoCare.aspx.

The definitions of the numerator and the denominator must be clearly stated for each stage. Applicants are strongly encouraged to use the same numerators and denominators as outlined for the HHS/HAB HIV Core Indicators. (http://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf ; http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html)

Include the five main stages of the HIV Care Continuum in the graph:

- **Diagnosed -** Number and percentage of people living with HIV/AIDS in the EMA/TGA diagnosed with HIV/AIDS.
- **Linked to Care -** Number and percentage of people living with HIV/AIDS in the EMA/TGA connected to an HIV healthcare provider.
- **Retained in Care -** Number and percentage of people living with HIV/AIDS in the EMA/TGA, receiving regular HIV medical care.
- **Prescribed Antiretroviral Therapy (ART) -** Number and percentage of people living with HIV/AIDS in the EMA/TGA, prescribed a combination of three or more antiretroviral drugs from at least two different HIV drug classes every day to control the virus.
- **Virally Suppressed -** Number and percentage of people living with HIV/AIDS in the EMA/TGA with a viral load below 200.

(2) The HIV Care Continuum depicted above illustrates the HIV epidemic for the EMA/ TGA. Utilizing the data from the graph, create a narrative which discusses the following:

a. How the HIV Care Continuum is currently or may be in the future utilized in planning, in prioritizing, in targeting and in monitoring available resources in response to needs of PLWH in the jurisdiction and in improving engagement at each stage in the continuum.

b. Current successes or possible improvements in supporting PLWH as they move from one stage in the continuum to the next.

c. Any gaps, barriers or unique challenges (i.e., data collection/ sharing, collaboration with other local, state and federal programs, etc.) that exist in developing and utilizing the HIV Care Continuum model in the Part A program. Describe how the Part A program addresses these gaps, barriers or unique challenges.

d. How will the FY 2015 award be used to address gaps/barriers and improve the HIV Care Continuum?

e. Any significant health disparities brought to light related to race, gender, sexual orientation and age among populations within your jurisdiction's HIV Care Continuum and activities targeted current or planned to

address these disparities.

B. FY 2015 Implementation Plan

The FY 2015 Implementation Plan demonstrates progress in impacting the HIV Care Continuum. The implementation plan is driven by stages of the HIV Care Continuum. The stages are consistent with the National HIV/AIDS Strategy goals. The implementation plan utilizes core medical and support service categories that are prioritized and funded by the planning council or through local community planning processes. The plan contains objectives and outcomes which are related to the Stages of the HIV Care Continuum, and demonstrate how funded services are implemented to achieve positive health outcomes and to promote access to high quality HIV care.

For additional information on the HHS seven common core indicators, refer
http://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf
http://blog.aids.gov/2012/08/secretary-sebelius-approves-indicators-for-monitoring-hhs-funded-hiv-services.html

The Implementation Plan is comprised of two main components:

(1) **RWHAP Implementation Plan: Service Category Table.**
The service category table illustrates how core medical and support services will be provided in the EMA/TGA. It is comprised of the service categories prioritized and funded by planning council or through local community planning processes. The objectives describe the specific end results that a service or program is expected to accomplish within a given time period and represent activities which have the greatest direct impact on the stages of the HIV Care Continuum. A service category may be related to more than one stage on the continuum. For example, Outpatient Ambulatory Medical Care impacts Linkage to Care, Retained in Care and Virally Suppressed.

a. List the EMA/TGA's **four** core medical service categories and **two** support service categories which comprise the largest amounts of Part A funding allocated on the FY 2015 Implementation Plan. For each of the core medical and support services listed, develop one or more time limited and measurable objectives. For MAI funds, list two service categories that comprise the largest amounts of MAI funding allocated for FY 2015 and use the same FY 2015 Implementation Plan format as for the Part A funding. For each objective, define the service unit, the number of persons to be served, the total number of service units to be delivered, and the estimated cost of meeting the objective.
b. These objectives will comprise one of two major elements of the FY 2015 Implementation Plan. Each service category should clearly provide a reference to the appropriate stage of the HIV Care Continuum and Outcome from the Ryan White Implementation Plan: HIV Care Continuum Table (see number 2. below)
c. The FY 2015 Implementation Plan should be placed in **Attachment 9** of the application.

(2) **RWHAP Implementation Plan: HIV Care Continuum Table (Attachment 9 continued)**

The RWHAP Implementation Plan: HIV Care Continuum Table tells the story of the Part A HIV Care Continuum in the jurisdiction. The table is comprised of the Stages of Change of the HIV Care Continuum, the Goal related to the stage, the Outcome related to the stage and a list of service categories utilized to achieve the goal related to the stage. The goal should be a broad statement that defines what will be accomplished and should state the impact on a stage of the HIV Care Continuum. The goal provides a framework for the objectives. A separate goal must be created for each stage of the HIV Care Continuum. Each stage also must have an outcome. The outcome must be one of the seven common core HHS indicators or one of the HAB Core performance measures related the stage of the HIV Care Continuum. The outcomes must include baseline data and establish a target. The baseline and target must be expressed as a numerator and denominator as well as the percent. The service categories related to the stage of the continuum are the final components of the table. This is a list of one or more service categories that will be funded to achieve the targets described in the outcome. The services categories should be those reflected in the Implementation Plan: Service Categories provided in number (1) above as well as all others that relate to the Stage of the HIV Care Continuum.

C. Implementation Plan Narrative

Based upon the FY 2015 Implementation Plan, provide a narrative that describes the following:

(1) Identify any prioritized core medical services that will not be funded with FY 2015 Ryan White HIV/AIDS Program funds and how these services will be delivered in the EMA/TGA; (e.g. services funded by Medicaid, Medicaid expansion, ACA marketplaces, SCHIP, etc.);
(2) How the activities described in the Plan will promote parity of HIV services throughout the EMA. Parity of services should be addressed in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness;
(3) How planned activities assure that services delivered by providers are culturally and linguistically appropriate to the populations served within the EMA/TGA;
(4) How the objectives, action items, and performance measures relate to the goals of Comprehensive Plan;
(5) How the EMA/TGA will ensure that resource allocations to provide services for WICY are in proportion to the percentage of EMA/TGA AIDS cases represented by each priority population; and
(6) How any recent EMA/TGA needs assessments or updates are linked or may be related to the HIV Care Continuum, including results of the EMA's/TGA's Unmet Need Framework and any new or different initiatives funded.

- *RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion #2*
  Discuss challenges that have been or likely to be encountered in integrating the HIV Care Continuum into planning and implementing the Part A program, and approaches that will be used to resolve such challenges.

- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion #3*

1. Clinical Quality Management (CQM)

The Ryan White HIV/AIDS Program legislation requires that Part A Grantees "provide for the establishment of a CQM program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent PHS guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services". The legislation allows grantees to use the lesser of 5 percent of the amount of the grant or $3,000,000 for the activities associated with a CQM program, and states that CQM is not counted towards the administrative expense cap (Sec. 2604 (h)(5) of the PHS Act).

CQM data plays a critical role in documenting that services delivered to clients are improving their health status. Information gathered through the CQM program, as well as client-level health outcomes data, should be used as part of the EMA/TGA planning process and ongoing assessment of progress toward achieving program goals and objectives, including improving the HIV Continuum of Care. It should also be used by the grantee to examine and refine services based on outcomes and the cost of delivering quality care.

Note: HAB has a portfolio of performance measures that include clinical, systems, medical case management, oral health and the AIDS Drug Assistance Program. Grantees can select appropriate performance measures from HAB's portfolio to compose a "local" portfolio of performance measures. Grantees should select performance measures that are most important to their programs and the populations they serve, as they relate to their overall goals for improving clinical health outcomes. The "local" portfolio should include measures for all funded service categories. Grantees are strongly encouraged to incorporate HAB's core measures into their portfolio and add other measures as appropriate. HAB's performance measures, as well as frequently asked questions, can be found online at: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

Links to the HHS HIV/AIDS guidelines (formerly called the Public Health Service Guidelines), the Ryan White HIV/AIDS Program legislation, and the resources and technical assistance (TA) available to grantees with respect to improving the quality of care, and establishing CQM programs may be found online at: http://hab.hrsa.gov/manageyourgrant/granteebasics.html.

HAB's Part A Program Monitoring Standards (including the standards for Quality Management) can be found online at: http://hab.hrsa.gov/manageyourgrant/files/programmonitoringparta.pdf.

A. Description of CQM Program Infrastructure:

(1) List the number of staff FTEs assigned to CQM.
(2) Describe the CQM program staff roles and responsibilities.
(3) Name the entity(s) under contract or to be contracted with for the CQM program, and activities the contractor has/will provide.

(4) Describe efforts to coordinate CQM activities with other Ryan White grantees in the jurisdiction.

B. Description of CQM Program Performance Measures:

(1) List the service categories for which the applicant has performance measures.
(2) List the performance measures for the upcoming year for outpatient/ambulatory medical care and medical case management. Describe the frequency of performance measure data collection from sub-grantees.
(3) Summarize the performance measure data collected for outpatient/ambulatory medical care and medical case management from the last grant year or calendar year, including any trending data.
(4) Describe how performance measure data are analyzed to evaluate for disparities in care and actions taken to eliminate disparities.
(5) Describe how stakeholders, including sub-grantees, consumers, and other Ryan White grantees in the jurisdiction and planning council/body contribute to the selection of performance measures and receive information about performance measure data.

C. Description of CQM Program Quality Improvement:

(1) Describe the processes for identifying priorities for quality improvement. Provide examples of specific quality improvement projects undertaken for outpatient/ambulatory medical care and medical case management. Describe the process to monitor and support sub-grantees' engagement in quality improvement projects.
(2) Describe efforts aimed at improving HIV viral suppression within the jurisdiction.
(3) Discuss how the CQM data have been used to improve and/or change service delivery in the EMA/TGA, including strategic long-range service delivery planning.
(4) Describe how stakeholders including sub-grantees, consumers, other Ryan White grantees in state, and planning council/body contribute to the selection of quality improvement activities undertaken by the applicant.

D. Data for Program Reporting

(1) Name and describe the information/ data system(s) within the EMA/TGA used for data collection and reporting operations.
(2) Describe the grantee's current client level data collection capabilities included in the Ryan White Service Report (RSR). Include the percentage of sub-grantees that were able to report CY 2013 client level data. Describe efforts to increase data completeness and validity.

- *ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criteria #4 and 5*

1. Grantee Administration

The purpose of this section is to demonstrate the extent to which the chief elected official (CEO) or designee in the EMA/TGA has met the legislative requirements to disburse funds quickly, closely monitor their use, and ensure the Ryan White HIV/AIDS Program is the payer of last resort. The Ryan White HIV/AIDS Program

stresses the importance of timely obligation of Ryan White HIV/AIDS Program funds. Timely obligation of Ryan White HIV/AIDS Program funds ensures that services can be provided as rapidly as possible, and decreases the possibility that unobligated funds will remain at the end of the program year. Please refer to Section 2603(c) (1), (2) and (3) of the PHS Act regarding the Part A formula and supplemental unobligated balance (UOB) requirement. The UOB requirement does not apply to MAI funds.

Note*: *UOB Penalties
If unobligated balances of formula award exceed five percent, two penalties are imposed:

1. *The future year award is reduced by the amount of UOB, less the amount of approved carryover; and*
2. *The grantee is not eligible for a future year supplemental award*

Note, that like all other grantees with UOB, the amount of UOB not covered by a waiver for carryover is subject to an offset.

If the grantee reports unobligated formula funds of five percent or less, no penalties are imposed ,although a future year award will be subject to an offset.

Supplemental Funds
Under the Ryan White HIV/AIDS Program legislation, the HHS Secretary has flexibility regarding supplemental funds. Grantees may not submit a carryover request for supplemental funds, which would permit those funds to be added to the subsequent grant year; instead, UOB supplemental funds are subject to an offset. UOB supplemental funds do not make a grantee ineligible for a future year supplemental award.

A. Program Organization

(1) Provide a description of how Part A funds are administered within the EMA/TGA with reference to the staff positions, including program and fiscal staff, described in the budget narrative and the organizational chart provided in **Attachment 10**. The narrative should describe: the local agency responsible for the grant and identify the entity responsible for administering the Part A Program, including the department, unit, staffing levels (FTEs, including any vacancies), fiscal agents, PC/planning body staff, and in-kind support staff. Describe the approaches to fill vacant staff positions that are essential for delivery, oversight, and monitoring of the Part A and MAI services/activities.

(2) Provide a descriptive narrative of the process and mechanisms, including data collection to ensure that providers funded through multiple Ryan White HIV/AIDS Program Parts (i.e. Parts A, B, C, D, and F), will be able to distinguish which clients are served by each individual funding stream to avoid duplication of services.

B. Grantee Accountability

HRSA/HAB holds grantees accountable for the expenditure of funds awarded under Part A and expects grantees to monitor fiscal and programmatic compliance with all contracts and other agreements for HIV/AIDS services in the EMA/TGA. Grantees are also required to have on file a copy of each contractor's procurement document (contracts), and fiscal, program, and site visit reports.

(1) **Program Oversight** - Provide a narrative that describes the following:

a. An update on the grantee's implementation of the National Monitoring Standards;
b. The process used to conduct program monitoring;
c. The total number of contractors funded in FY 2014; the frequency of monitoring site visits (both programmatic and fiscal) and the generation of reports during a program year; the number and percentage of contractors that have received a fiscal and/or programmatic monitoring site visit to date, and the total number planned for the FY 2015 grant year;
d. The process and timeline for corrective actions when a fiscal or programmatic-related concern is identified; any improper charges or other findings in FY 2014 to date and a summary of the corrective actions planned or taken to address these findings;
e. The number of contractors that have received technical assistance (TA) for FY 2014, to date (types of TA, scope, and timeline).

(2) **Fiscal Oversight -** Provide a narrative that describes the following information:

a. The process used by program and fiscal staff to coordinate activities, ensuring adequate reporting, reconciliation, and tracking of program expenditures (i.e. meeting schedule, information sharing regarding contractor expenditures, UOB, and program income);
b. The process used to separately track formula, supplemental, MAI, and carry over funds, including information on the data systems utilized;
c. The process used to ensure timely monitoring and redistribution of unexpended funds;
d. The process for reviewing contractors compliance with the audit requirement in OMB Circular A-133;
e. If there were findings in any contractors' A-133 audit reports, describe what the grantee has done to ensure that contractors have taken appropriate corrective action. Corrective actions may include, but are not limited to, HRSA/HAB sponsored TA and training requests from the grantee of record; and
f. The process for reimbursing contractors, from the time a voucher/invoice is received to payment.

C. Third Party Reimbursement

The Ryan White HIV/AIDS Program is the payer of last resort, and grantees must make every effort to ensure that alternate sources of payments are pursued and that program income is used consistent with grant requirements. HRSA expects grantees to screen for proof of insurance status and financial eligibility for use of

funds on a regular basis (see http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf). Grantees are required to use effective strategies to coordinate between Part A and third party payers who are ultimately responsible for covering the cost of services provided to eligible or covered persons. Third party sources include Medicaid and any opportunities for expansion under the Affordable Care Act, Children's Health Insurance Programs (CHIP), Medicare, including Medicare Part D, and private insurance, including new options available under the health insurance marketplace established by the Affordable Care Act. Contractors providing Medicaid eligible services must be Medicaid certified.

(1) Provide a narrative that describes the following:
   a. The process used by grantees to ensure that contractors are monitoring third party reimbursement; also describe the contract language or other mechanism to ensure that this takes place;
   b. The process to conduct screening and eligibility to ensure the RWHAP is the payer of last resort; and
   c. How the grantee monitors the appropriate tracking and use of any program income at both the grantee and contractor level.

D. Administrative Assessment

The Ryan White HIV/AIDS Program mandates that EMA/TGA PCs must assess the efficiency of the administrative mechanism to rapidly allocate funds to the areas of greatest need within the EMA/TGA.

(1) Provide a narrative that describes the results of the PC's assessment of the administrative mechanism in terms of:
   a. Assessment of grantee activities to ensure timely allocation/contracting of funds and payments to contractors; and
   b. If any deficiencies were identified by the PC, what were the deficiencies, what was the grantee's response to those deficiencies, and what is the current status of the grantee's corrective actions?

E. Maintenance of Effort (MOE)

The Ryan White HIV/AIDS Program legislation requires Part A Grantees to maintain, as a Condition of Award, EMA/TGA political subdivision expenditures for HIV-related core medical services and support *services at a level equal to the 1-year period preceding the FY for which the grantee is applying to receive a Part A grant. After enactment of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Section 2604(b)(1) of the PHS Act states: "In general – The chief elected official of an eligible area shall use amounts from a grant under Section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services." Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the PHS Act and HAB's service definitions distributed to all grantees. Part A Grantees must document that they have met the MOE requirement.*

To demonstrate that grantees understand this revision to the Part A MOE requirement, applicants must submit in this section the following information as **Attachment 11**:

(1) A table that identifies the MOE budget elements and the amount of expenditures related to HIV/AIDS core medical and support services for FYs 2012 and 2013; and

(2) A description of the process used to determine the amount of expenditures in the table.

iii. Budget and Budget Justification Narrative

Reminder: The Total Project or Program Costs are the total allowable costs (inclusive of direct **and** indirect costs) incurred by the recipient to carry out a grant-supported project or activity. Total project or program costs include costs charged to the award and costs borne by the recipient to satisfy a matching or cost-sharing requirement.

See Section 4.1.iv and v. of HRSA's *SF-424 Application Guide*. In addition, the Ryan White Part A HIV Emergency Relief Grant Program requires the following:

Complete Application Form SF-424A Budget Information – Non-Construction Programs provided with the application package. Please complete Sections A, B, and F.

Under Section B, Budget Categories, use the following column headings:

a. "Administrative"
b. "Clinical Quality Management"
c. "MAI"
d. "HIV Services"

Personnel and fringe benefits for program staff assigned to these budget categories should be placed on the appropriate line.

Provisions enacted in the Consolidated Appropriations Act, 2014 continue in 2015. The Consolidated Appropriations Act, 2014, Division H, § 203, (P.L. 113-76) states, "None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.". Please see Section 4.1.iv Budget – Salary Limitation of HRSA's *SF-424 Application Guide* for additional information.

On the contractual services line-item list determine the amounts allocated for personnel or services contracted to outside providers for all HIV services. Show the amount allocated to any activities that are not conducted "in-house" on the Contractual line.

Grantee administration and planning council support or planning body support are all considered within the Grantee Administration budget, and together are capped at 10 percent. Grantees must determine the amounts necessary to cover all administrative and program support activities. The grantee must also ensure adequate funding for PC mandated functions within the administrative line item. "Planning Council support should cover *reasonable and necessary costs* associated with carrying out legislatively mandated functions."

In addition to the SF-424A, submit a budget narrative in table format **on the Budget Narrative Attachment form.** The budget narrative table should explain the amounts requested for each line in the budget by column headings listed, and explain how the line items listed support the overall Part A HIV service delivery system. The budget narrative table should clearly state how each object class category's efforts and/or activities make a contributing impact to support the Part A HIV service delivery system. Include a justification column that clearly explains the activities which impact the Part A HIV service delivery system. In addition, under the personnel object class category, all costs must include the name, position title, and FTE allotment.

Caps on expenses: Part A Grantee Administration Costs (including PC support) may **not** exceed 10 percent of the grant award. Administrative expenditures for first- line entities or sub-contractors may **not** exceed 10 percent of the aggregate amount allocated for services. **Reminder: Indirect costs are considered an administrative cost, which is capped at 10 percent of the grant award**. Grantees are allowed to allocate up to 5 percent of the total grant award or $3,000,000 (whichever is less), for CQM activities.

Administrative Costs are those costs associated with the administration of the Part A grant. By law, no more than 10 percent of the Part A budget can be spent on administrative costs. Sub-contractor administrative costs are capped at **10 percent in the aggregate.** Staff activities that are administrative in nature should be allocated to administrative costs. Examples of administrative costs at the grantee and sub-contractor level include:

- Indirect Costs, which are allowed only if the organization has a negotiated indirect cost rate approved by a cognizant federal agency. A copy of the latest negotiated cost agreement that covers the period for which funds are requested must be submitted as **Attachment 13** of the application (not counted in the page limit). Indirect costs are those costs incurred by the organization that are not readily identifiable, with a particular project or program, but are considered necessary to the operation of the organization and performance of its programs. All indirect costs are considered administrative for the Part A Program and, therefore, are subject to the 10 percent limitation on administrative expense.
- Operation and maintenance expenses including costs incurred for the administration, supervision, operation, maintenance, preservation, and protection of the grantee's and sub-contractors' physical facility; they include expenses normally incurred for such items as janitorial and utility services; repairs and ordinary or normal alterations of buildings, furniture and equipment; care of grounds; maintenance and operation of buildings and other facilities; security; earthquake and disaster preparedness; environmental safety; hazardous waste disposal; property, liability and all other insurance relating to property; space and capital leasing; facility planning and management; and central receiving.
- Rent, occupancy costs, utilities, and other facility support costs related to management of grant funds.
- PC support and related activities including assessment of the administrative mechanism.
- Personnel costs and fringe benefits of staff members responsible for the management of the grant.
- Costs associated with the grantee's contract award procedures including: development of requests for proposals (RFPs), drafting, negotiation, awarding, and

monitoring of contract awards.

- Costs associated with audits, payroll/accounting functions, medical coding and medical billing, human resources and recruitment.
- Costs associated with implementing national monitoring standards, including monitoring of sub-contractors.
- Telecommunications, including telephone, fax, pager and internet access.
- Postage.
- Office supplies.
- Computer hardware and software not directly related to patient care.
- Program evaluation, including data collection for evaluation.
- Office administrator, file clerk, clinic receptionist, and appointment reminder calls.
- Electronic health records, maintenance, licensure, annual updates, and data entry.
- Office equipment lease.
- Copying and printing.
- Program development and strategic planning.

Clinical Quality Management (CQM) Costs are those costs required to maintain a clinical quality management program to assess the extent to which services are consistent with the current HHS guidelines for the treatment of HIV/AIDS. Examples of clinical quality management costs include:

- Clinical Quality Management coordination;
- Continuous Quality Improvement (CQI) activities;
- Data collection for clinical quality management purposes (collect, aggregate, analyze, and report on measurement data);
- Grantee CQM staff training/ TA (including travel and registration) - this includes HRSA sponsored or HRSA approved training; and
- Training of sub-contractors

Minority AIDS Initiative (MAI) costs are intended to address the disproportionate impact that HIV/AIDS has on racial and ethnic minorities and to address the disparities in access, treatment, care, and outcomes for racial and ethnic minorities, including African-Americans, Alaska Natives, Hispanic/Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders.

HIV Services are **direct service** costs associated with the direct provision of Core Medical Services or Support Services. Staff positions such as medical assistants, dental hygienists, and nurses can be included in the budget when the position proportionately complements HIV primary medical care providers, such as physicians, dentists, physician assistants, or nurse practitioners being funded by the Part A Program. Some of the costs that are considered **direct services** under Core Medical Services include:

- Salaried personnel, contracted personnel or visit fees to provide core medical services directly to the HIV-infected client, including primary medical care, laboratory testing, oral health care, outpatient mental health, medical nutrition therapy, outpatient substance abuse treatment, specialty and subspecialty care. Provider time must be reasonable for the number of clients;

- Lab, x-ray, and other diagnostic tests;

- Medical/dental equipment and supplies; and
- Other clinical and diagnostic services regarding HIV/AIDS and periodic medical evaluations of individuals with HIV/AIDS, according to the DHHS guidelines. http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0/
- Salaried or contracted personnel that provides outreach to and linkage to enrollment of RWHAP clients into health insurance coverage as a component of EIS. Referrals and linkages to care may include enrollment in Medicaid, Medicare, private insurance plans through the health insurance Marketplaces/Exchanges, and benefits counseling. Services are generally provided to clients who are new to care.
- Salaried or contracted personnel that provides outreach to and enrollment of RWHAP clients into health insurance coverage as a component of medical case management services; this may include benefits/entitlement counseling and referral activities to assist clients with access to other public and private programs for which they may be eligible (e.g., Medicaid, Marketplaces/Exchanges, Medicare Part D, State Pharmacy Assistance Programs, and other state or local health care and supportive services). Services are provided to prevent clients from falling out of care.

Support Services Costs are those costs for services which are needed for individuals living with HIV/AIDS to achieve optimal HIV medical outcomes. Some of the costs that are considered **direct services** under "support services" include:

- Salaried personnel, contracted personnel, or visit fees to provide support services directly to the HIV-infected or affected client;
- Salaried or contracted personnel that provides outreach to and enrollment of Ryan White HIV/AIDS Program (RWHAP) clients into health insurance coverage as a component of case management or referral for health and supportive services. This may include benefits/entitlement counseling and referral activities as allowable activities. Services that are provided to prevent clients from falling out of care. Referral for health and supportive services are generally provided to clients who have a change in insurance status, new eligibility, or require a change in treatment regimen;
- Salaried or contracted personnel that provide outreach to and enrollment of Ryan White HIV/AIDS Program (RWHAP) clients into health insurance coverage as a component of case management services; this may include benefits/entitlement counseling and referral activities as allowable activities. Services are provided to prevent clients from falling out of care;
- Peer to peer education/support;
- Patient navigators/community health worker aide; and
- Local travel by staff to provide support services.
- Under certain **limited circumstances**, rent may be an allowable direct service expense:
    - ➢ A food bank may charge rent as a direct service in some specific cases. For example - pantry where the food is stored or location where prepared bags of food may be picked up by the client. Grantee must work with a HRSA project officer to ensure the charge is *allowable.*
    - ➢ Residential substance abuse agencies may charge rent as a direct service for the rent of the residential facility for a specific timeframe.
    - ➢ Emergency financial assistance or housing services when Ryan White Part A

funds are used to cover all or a portion of a client's rent.

iv. Attachments

Please provide the following items in the order specified below to complete the content of the application. Unless otherwise noted, attachments count toward the application page limit. Indirect cost rate agreements and proof of non-profit status (if applicable) will not count toward the page limit. **Each attachment must be clearly labeled**.

Attachment 1: Staffing Plan, Job Descriptions, and Biographical Sketches for Key Personnel (see section 4.1. of the HRSA's SF-424 Application Guide)

Attachment 2: Letters of Agreement, Memorandum of Understanding, Intergovernmental Agreements, FY 2014 Agreements and Compliance Assurances, Certifications
In addition to completing the SF-424B Assurances per instructions in the *SF-424 Application Guide*, also complete and submit the required Part A Grant Program FY 2015 Agreements and Compliance Assurances (see Appendix A), which should be submitted as part of **Attachment 2**

Attachment 3: HIV/AIDS Demographic Table

Attachment 4: Unmet Need Framework

Attachment 5: Co-morbidities, Cost and Complexity Table

Attachment 6: Coordination of Services and Funding Table

Attachment 7: Letter of Assurance from Planning Council Chair/Letter of Concurrence from Planning Body

Attachment 8: Planned Services Table, Core Medical Services Waiver Request (if applicable)

Attachment 9: FY 2015 Implementation Plan and HIV Care Continuum Table

Attachment 10: Organizational Chart

Attachment 11: Maintenance of Effort Documentation
Applicants must provide a baseline aggregate expenditure for the prior fiscal year (unless otherwise noted in statute), using a table that includes the item number, item description, agency/department unit, and related expenditures for FYs 2012 and 2013.

Attachment 12: ***Other Relevant Documents (Corrected from Budget Narrative Attachment)***
Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) List all other support letters on one page. DO NOT ATTACH BUDGET NARRATIVE UNDER THIS ATTACHMENT.

Attachment 13: Federally Negotiated Indirect Cost Rate Agreement (if applicable, not counted in the page limit).

Attachments 14 – 15: Other Relevant Documents
Include here any other documents that are relevant to the application, including letters of support. Letters of support must be dated and specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) List all other support letters on one page.

3. Submission Dates and Times

Application Due Date
The due date for applications under this funding opportunity announcement is *September 19, 2014 at 11:59 P.M. Eastern Time*.

4. Intergovernmental Review

The Ryan White Part A Emergency Relief Grant Program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. See Executive Order 12372 in the HHS Grants Policy Statement.

See Section 4.1 ii of HRSA's *SF-424 Application Guide* for additional information.

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to one (1) year.

Funds under this announcement may not be used for the following purposes:

- Construction is not allowable. Minor alterations and renovations to an existing facility, to make it more suitable for the purpose of the grant program are allowable with prior HRSA approval;
- Entertainment costs are not allowable; this includes the cost of amusements, social activities, and related incidental costs;
- Fundraising expenses are not allowable;
- Lobbying expenses are not allowable;
- International travel is not allowable;
- Pre-Exposure Prophylaxis (PrEP) or non-occupational Post-Exposure Prophylaxis (nPEP) – Ryan White HIV/AIDS Program funds cannot pay for PrEP or nPEP, as the person using PrEP or nPEP is not HIV infected, and therefore is not eligible for Ryan White HIV/AIDS Program funded medication; and
- Payment for any item or service to the extent that payment has been made (or reasonably can be expected to be made), with respect to that item or service, under any state compensation program, insurance policy, federal or state benefits program, or any entity that provides health services on a prepaid basis, (except for a program administered by or providing the services of the Indian Health Service).

Other non-allowable costs can be found in the appropriate OMB Circular, available at http://www.whitehouse.gov/omb/circulars/.

The General Provisions in Division H, Title V of the Consolidated Appropriations Act, 2014 (P.L. 113-76), apply to this program. Please see Section 4.1 of HRSA's *SF-424 Application Guide* for additional information. Note that these or other restrictions will apply in FY 2015, as required by law.

All program income generated as a result of awarded grant funds must be used for approved project-related activities.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

These criteria are the basis upon which the reviewers will evaluate the application. The entire proposal will be considered during objective review.

Review Criteria are used to review and rank applications. The Ryan White Part A Program has five review criteria:

Criterion 1: NEED (67 points) – Corresponds to Section IV's, ii, Project Narrative: Introduction, Needs Assessment/Jurisdictional Profile, Demonstrated Need, Impact of Funding and associated attachments. Note: This section includes EIIHA which is 33 points per legislation.

The extent to which the application demonstrates the problem and associated contributing factors to the problem.

1. Jurisdictional Profile (7 points)

(1) HIV/AIDS Epidemiology Table is clear, complete, and consistent with the information in the narrative. The sources for all data are clearly identified.
(2) HIV/AIDS Demographic Table (**Attachment 3**) is clear, complete, and consistent with the information in the narrative. The sources for all data are clearly identified.
(3) The narrative description depicts the current HIV disease, as it relates to disproportionate impact on certain populations, under-represented populations, and new/emerging populations is clear and comprehensive.

2. Demonstrated Need (48 points)

A. Unmet Need (7 points)

(1) The clarity and completeness of the applicant's Unmet Need framework estimates (using **Attachment 4)** which should include data sources and calculations.
(2) The table showing the percentage of Unmet Need for PLWA and PLWH is clear, complete, and consistent with the trends described in the narrative. The narrative clearly describes the trends in the Unmet Need percentages and what attributed to those trends.
(3) The applicant clearly describes how the Unmet Need populations are considered in planning and decision-making processes and how information is used to assist PLWA and PLWH in accessing primary medical care.

B. Early Identification of Individuals with HIV/AIDS (EIIHA 33pts)
***EIIHA Data* (14 pts)**

(1) For the selected three target populations, the extent to which the applicant provided the following complete data for January 1, 2014 – June 30, 2014**:**

Newly diagnosed positive HIV test events

a. Number of test events
b. Number of newly diagnosed positive test events
c. Number of newly diagnosed positive test events with client linked to HIV medical care
d. Number of newly diagnosed confirmed positive test events
e. Number of newly diagnosed confirmed positive test events with client interviewed for partner services
f. Number of newly diagnosed confirmed positive test events with client referred to prevention services
g. Total number of newly diagnosed clients with confirmed positive test events who received CD4 cell count and viral load testing.

Previously diagnosed positive HIV test events

a. Number of test events
b. Number of previously diagnosed positive test events
c. Number of previously diagnosed positive test events with a client re-engaged in HIV medical care
d. Number of previously diagnosed confirmed positive test events
e. Number of previously diagnosed confirmed positive test events with a client interviewed for partner services.
f. Number of previously diagnosed confirmed positive test events with client referred to prevention services
g. Number of previously diagnosed confirmed positive test events linked to and accessed CD4 cell count and viral load testing

***FY15 EIIHA Plan* (19 pts)**

(1) The extent to which the applicant described the planned activities of the EMA/TGA's EIIHA Plan for FY15**:**

a. Provided an updated estimate of individuals who are HIV positive and who are unaware of their status, including the estimate methodology;
b. Described all populations for the EIIHA Plan;
c. Described the primary activities that will be undertaken, including system level interventions e.g. routine testing in clinical settings, expanding partner services;

d. Identified major collaborations with other programs and agencies, including HIV prevention and surveillance programs; and
e. Described the planned outcomes of your overall EIIHA strategy.

(2) The extent to which the applicant described how the overall FY 2015 EIIHA Plan contributes to the goals of the National HIV/AIDS Strategy and the White House HIV Continuum of Care Initiative.

(3) The extent to which the applicant described how the Unmeet Need estimate and activities related to the Unmet Need population inform and relate to the EIIHA planned activities.

(4) The extent to which the applicant described how the EIIHA Plan for FY 2014 (e.g. process, activities and outcomes) influenced the development of the EIIHA Plan for FY 2015.

(5) The extent to which the applicant described any planned efforts to remove legal barriers, including State laws and regulations, to routine HIV testing.

(6) The applicant selected three (3) distinct target populations for the FY 2015 EIIHA Plan. For each selected target population a clear description was provided on:
a. Why the target population was chosen and how the epidemiological data, Unmet Need estimate data, or other data supports that decision;
b. Specific challenges with or opportunities for working with the targeted population;
c. Specific activities that will be utilized with the target population;
d. Specific objectives for each component of EIIHA (identify, inform, refer, and link to care) for the target population (all objectives should be written as S.M.A.R.T objectives – **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime phased);
e. The responsible parties, including any coordination with other agencies and/or programs for ensuring each of the activities are implemented, and their respective roles;
f. Planned outcomes that will be achieved for the target population as a result of implementing the EIIHA Plan activities.

(7) The extent to which the applicant described plans to present, discuss, and/or disseminate the EIIHA Plan, and outcomes of EIIHA Plan activities to stakeholders e.g. poster presentations, journal articles, presentations to planning bodies.

C. Unique Service Delivery Challenges (2 points)

(1) If applicable, the applicant provided a compelling narrative description of the need for HIV/AIDS emergency grant funds in the EMA/TGA, based on factors not already discussed. The narrative describes the unique service delivery challenges in terms of service costs, changes in service providers, and the complexity of

providing care.

D. Minority AIDS Initiative (6 points)

(1) The extent to which the applicant clearly identified minority populations based on data presented in the epidemiology table, narrative on new/emerging populations, if applicable (FOA page 8), and specific sub-groups targeted with MAI funds.

(2) The extent to which activities described are clearly linked to the planning process and service delivery categories under MAI.

(3) The extent to which the applicant clearly described two activities that will reduce barriers and enhance effectiveness of HIV services provided to specific minority populations and its impact on the HIV Continuum of Care.

3. <u>Impact of Funding (12 points)</u>

A. Impact of the Affordable Care Act (4 points)

(1) The extent to which the applicant provided a table with available data on PLWH who are uninsured and living in poverty in their jurisdiction.

(2) The extent to which the applicant provided a narrative based on available information on the impact of insurance expansion, outreach and enrollment, marketplace options, and successes and outcomes.

B. Impact of Co-morbidities on Cost and Complexity of Providing Care (4 points)

(1) The strength of the narrative description, based on the table in **Attachment 5 o**f the impact of co-morbidities and co-factors on the cost and complexity of care in the EMA/TGA.

C. Coordination of Services and Funding Streams (4 points)

(1) The clarity and completeness of the table "Coordination of Services and Funding Streams" (**Attachment 6)** in describing the availability of other public funding in the EMA/TGA. The quality of the table to include both the dollar amount(s) and the percentage of the total available funds in 2014, and the anticipated funds in 2015 for the following:

a. other Ryan White HIV/AIDS Program funding (Parts B, C, D, and F);
b. federal/state and local sources of public funding; and
c. HIV/AIDS-related service funds available in FY 2014 and anticipated in FY 2015.

Criterion 2: RESPONSE (15 points) – Corresponds to Section IV's, ii, Project Narrative: Methodology/Planning and Resource Allocation, Work Plan/HIV Continuum of Care and FY 2015 Implementation Plan, Resolution of Challenges and associated attachments

The extent to which the proposed project responds to the "Purpose" included in the program description. The strength of the proposed goals and objectives and their relationship to the identified project. The extent to which the activities (scientific or other) described in the application are capable of addressing the problem and attaining the project objectives.

1. Planning and Resource Allocation (6 pts.)

A. The Letter of Assurance or Concurrence signed by the PC chair(s) or planning body leadership fully addressed the following components (1 point):

(1) The FY 2014 formula, supplemental, and MAI funds awarded to the

EMA/TGA are being expended according to the priorities established by the PC;

(2) That all FY 2014 Conditions of Award relative to the PC have been addressed;
(3) The FY 2014 priorities were determined by the PC, and the approved process for establishing those priorities was used by the PC;
(4) Date of annual membership training took place; and
(5) Representation is reflective of the epidemic; if there are vacancies, a plan and timeline to address each vacancy; if applicable, noted variations between demographics of non-aligned consumers and HIV disease prevalence of the EMA or TGA.

B. Description of the Community Input Process (3 points)

(1) The extent to which the applicant clearly documents the existence of a functioning planning process in the EMA or TGA that describes community input, priority setting, and allocations processes.
(2) The extent to which the applicant provides a clear description of how the prioritization and allocation process addresses the data and information presented in the Need section of the application.
(3) The extent to which the applicant provides a clear description of how data from various sources (i.e. epidemiology data, cost data, federally funded HIV/AIDS programs etc.) were used in the planning and allocation process.
(4) The extent to which the applicant provides a description of how PLWH were involved and how their priorities were considered in the planning and allocation process.
(5) The extent to which the applicant provided a clear description of how MAI funding was considered during the planning process.
(6) The extent to which the applicant clearly described how anticipated changes due to the Affordable Care Act were considered in developing priorities.

C. Funding for Core Medical Services (2 points)

Submission of a table that lists all the planned services for FY 2015 and addresses the 75 percent core medical services allocation requirement. The Planned Services Table and the Core Medical Services Waiver request, (if applicable) should be included as **Attachment 8.**

2. HIV Care Continuum and FY 2015 Implementation Plan (8 pts)

A. HIV Care Continuum (2 points)

(1) The clarity and completeness of the description of the HIV Care Continuum, including a graph depicting the data presented; assess how well these match the gaps identified in the Need section.

B. FY 2015 Implementation Plan (6 points)

(1) The clarity and completeness of the FY 2015 Implementation Plan that includes all the stages of the continuum, goals, outcomes and service categories. **Note: The HIV Care Continuum Table should not be scored.**

(2) The completeness of the Plan for each service category related to the HIV Care Continuum. The objectives to be funded and how they are clearly linked to a specific stage(s) of the HIV Care Continuum:
   - A service unit definition that clearly and consistently measures the objective (e.g. a one-hour face-to-face encounter, one round-trip bus ride, one primary care visit);
   - The number of people who will be served;
   - The total number of service units that will be provided; and
   - The estimated cost (funded by Part A and/or by MAI) for meeting each objective during the time periods.

(3) The comprehensiveness and strength of the narrative that supports the FY 2015 Implementation Plan. The extent to which the narrative expands and clarifies the information presented in the Plan and describes the following:
   - Prioritized core medical services that will not be funded with FY 2015 Ryan White HIV/AIDS Program funds and how these services will be delivered in the EMA/TGA; (e.g. services funded by Medicaid, Medicaid expansion, Affordable Care Act marketplaces, SCHIP, etc.)
   - How the activities described in the Plan will promote parity of HIV services throughout the EMA. Parity of services should be addressed in terms of geographic location of services, quality, comprehensiveness of services, and cultural appropriateness;
   - How planned activities assure that services delivered by providers are culturally and linguistically appropriate to the populations served within the EMA/TGA;
   - How the objectives, action items, and performance measures relate to goals of the Comprehensive Plan;
   - How the EMA/TGA will ensure that resource allocations to provide services for WICY are in proportion to the percentage of EMA/TGA AIDS cases represented by each priority population; and
   - How any recent EMA/TGA needs assessments or updates (including results of the EMA's/TGA's Unmet Need framework) are linked with the HIV Care Continuum.

2. <u>Resolution of Challenges (1 point)</u>

The applicant clearly discusses challenges that have or likely to be encountered in integrating the HIV Care Continuum into planning and implementing the Part A program and approaches that were or will be used to resolve such challenges.

Criterion 3: EVALUATIVE MEASURES (5 points) – Corresponds to Section IV's, ii, Project Narrative: Evaluation and Technical Support Capacity/CQM

1. <u>Clinical Quality Management (CQM) (5 points)</u>

(1) Infrastructure: The extent to which the applicant provided a clear description of the CQM Program staff, FTEs, roles, responsibilities, contracted staff and activities undertaken by contractor, and coordination of activities with other Ryan White grantees in jurisdiction.

(2) Performance measurement: The extent to which the applicant provided a detailed list the service categories for which the applicant has performance measures; clearly described specific performance measures that are monitored by outpatient/ambulatory medical care and medical case management service categories and frequency at which performance measure data are collected from subgrantees; and summarized performance measure data including trends for outpatient/ambulatory medical care and medical case management; and clearly described how performance measure data are analyzed to evaluate for disparities in care and actions taken to eliminate disparities;

(3) Quality Improvement: The extent to which the applicant clearly described the processes for identifying priorities for quality improvement, examples of specific quality improvement projects undertaken for outpatient/ambulatory medical care and medical case management, and clearly described the process to monitor and support subgrantees engagement in quality improvement projects; and clearly described efforts aimed at improving HIV viral suppression within the jurisdiction.

Criterion 4: RESOURCES/CAPABILITIES (10 points) – Corresponds to Section IV's, ii, Project Narrative: Organizational Information/Grantee Administration and associated attachments

1. Grantee Administration

A. <u>Program Organization (2 points)</u>

(1) The extent to which the applicant provided a narrative that described the following:

a. A clear and complete description of the local agency responsible for the grant and identifies the entity responsible for administering the Part A Program. Included should be the department, unit, staffing levels (FTEs, including any vacancies), fiscal and/or management agents, planning and evaluation bodies, and in-kind support staff;

b. A viable process and mechanisms, including data collection used to ensure providers funded through multiple Ryan White HIV/AIDS Program Parts (i.e. Parts A, B, C, D, and F) distinguish which clients are served by each individual funding stream to avoid duplication of services;

B. <u>Grantee Accountability (8 points)</u>

Program Oversight

(1) The applicant provides a narrative that describes the following:

a. The strength and feasibility of the steps taken by the EMA/TGA in 2014 to implement the National Monitoring Standards;

b. The frequency of fiscal and programmatic monitoring site visits during a program year, and the process and timelines for corrective actions when a fiscal or programmatic-related concern is identified; and

c. Any improper charges or other findings in FY 2014, to date, and a summary of the corrective actions planned or taken to address these findings, as well as the number of contractors that received TA in FY 2014, to date (types, scope, and timeline of TA).

Fiscal Oversight
The applicant provides clear documentation and description of the following:

(1) A comprehensive description of the process used by program and fiscal staff to coordinate activities ensuring adequate reporting, reconciliation, and tracking of program expenditures.

(2) A clear description of the process used to separately track formula, supplemental, MAI, and carry over funds, including information on the data systems utilized, and the process used to ensure timely monitoring and redistribution of funds.

(3) A detailed description of a coordinated process for reviewing contractor compliance with the audit requirement in OMB Circular A-133; and, if there were findings in any sub-contractors' A-133 audit reports; what the grantee has done to ensure that sub-contractors have taken appropriate corrective action.

(4) A detailed description of the process for reimbursing contractors/sub-contractors, from the time a voucher/invoice is received to a payment being made.

Criterion 5: SUPPORT REQUESTED (3 points) – Corresponds to Section IV's, ii, Project Narrative: Organizational Information, MOE, Budget and associated attachments

The reasonableness of the proposed budget in relation to the objectives, the complexity of the activities, and the anticipated results.

Budget and Maintenance of Effort (MOE) Documentation

(1) The reasonableness and completeness of the SF 424A, with the required categories.

(2) The clarity and strength of the budget justification, with descriptions that explain the amounts requested for each line in the budget as it relates to the needs described in the Need section.

(3) The clarity and completeness of the documentation describing how the EMA/TGA met the MOE legislative requirement, as supported by the MOE Table, included with the application. A clear and thorough description of the process for identifying and tracking core medical services, and support services budget elements used to calculate the MOE.

2. Review and Selection Process

Please see section 5.3 of the HRSA's *SF-424 Application Guide*.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of March 1, 2015.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of March 1, 2015. See Section 5.4 of HRSA's *SF-424 Application Guide* for additional information.

2. Administrative and National Policy Requirements

See Section 2 of HRSA's *SF-424 Application Guide*.

Implementation of United States v. Windsor and Federal Recognition of Same-sex Spouses/Marriages

The following policy applies to:

- all grants except block grants governed by 45 CFR part 96, part 98, and grant awards made under titles IV -A, XIX and XXI of the Social Security Act.
- programs which base eligibility or otherwise make distinctions in program participation or content on such terms as "marriage," "spouse," "family," "household member," or similar references to familial relationship.

A standard term and condition of award will be included in the final Notice of Award (NOA) that states: "In any grant-supported activity in which family, marital, or household considerations are, by statute or regulation, relevant for purposes of determining beneficiary eligibility or participation, grantees must treat same-sex spouses, marriages, and households on the same terms as opposite-sex spouses, marriages, and households, respectively. By "same-sex spouses," HHS means individuals of the same sex who have entered into marriages that are valid in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "same-sex marriages," HHS means marriages between two individuals validly entered into in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "marriage," HHS does not mean registered domestic partnerships, civil unions or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than a marriage."

3. Reporting

The successful applicant under this funding opportunity announcement must comply with Section 6 of HRSA's *SF-424 Application Guide* and the following reporting and review activities:

1) **Progress Report**(s). The awardee must submit a progress report to HRSA on an annual basis. Further information will be provided in the award notice.

2) **Program Terms Report.** The awardee must submit a program terms report to HRSA ninety (90) days after the award is made; further information will be provided in the notice of award.

3) **MAI Annual Plan and Report.** The awardee must submit an annual plan on the proposed services provided with MAI funds, as well as an annual report on the outcomes of the services provided; further information will be provided in the notice of award.

4) **Expenditure Table.** The awardee must submit a table on Part A and MAI expenditures; further information will be provided in the notice of award.

5) **Ryan White Services Report**. Acceptance of this award indicates the grantee assures it will comply with data requirements of the Ryan White Services Report (RSR) and that it will mandate compliance by each of its contractors and sub-contractors. The RSR captures information necessary to demonstrate program performance and accountability.

6) **Client level Data Report**. All Ryan White HIV/AIDS Program core services and support services providers are required to submit client level data for CY 2014. Please refer to the HIV/AIDS Program Client Level Data website at http://hab.hrsa.gov/manageyourgrant/techdataassistance.html for additional information.

7) **Waiver to Request Carryover.** The Ryan White HIV/AIDS Program legislation requires a waiver to request carryover of unobligated formula funds before the end of the grant year. A carryover waiver application, together with the estimated unobligated balance (UOB), must be submitted to HRSA/HAB, stating the purpose for which such funds will be expended during the carryover year, no later than December 31, (with an automatic extension to the first workday following December 31, if it is a weekend or holiday).

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Karen Mayo, Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 18-75
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-3555
Fax: (301) 594-4073
Email: KMayo@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Steven R. Young, MSPH
Director, Division of Metropolitan HIV/AIDS Programs
Attn: Funding Program
HIV/AIDS Bureau, HRSA
Parklawn Building, Room 9W12
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-9091
Fax: (301) 443-5271
Email: SYoung@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726 (International Callers, please dial 606-545-5035)
E-mail: support@grants.gov
iPortal: https://grants-portal.psc.gov/Welcome.aspx?pt=Grants

Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Call Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
E-mail: CallCenter@HRSA.GOV

VIII. Other Information

All applicants are encouraged to participate in a technical assistance (TA) webinar for this funding opportunity. The technical assistance webinar is tentatively scheduled for August 7, 2014 from 2-4PM Eastern Time. The purpose of this webinar is to assist potential applicants in preparing applications that address the requirements of this funding announcement. Participation in a pre-application TA webinar is optional.

Dial-in Phone Number: 1-800-857-6259
Passcode: 7527379
To access the webinar online, go to the Adobe Connect URL:
https://hrsa.connectsolutions.com/2015FOA/

IX. Tips for Writing a Strong Application

See Section 4.7 of HRSA's *SF-424 Application Guide*.

Appendix A

FY 2015 AGREEMENTS AND COMPLIANCE ASSURANCES
Ryan White HIV/AIDS Program
Part-A Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area Marcellina A. Ogbu, (hereinafter referred to as the EMA/TGA) assure that:

Pursuant to Section 2602(a)(2) 1, 2
The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)
The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last 5 years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2602(b)(4)
The EMA/TGA Planning Council will determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

Pursuant to Section 2603(c)
The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)
The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council.

Pursuant to Section 2604(a)
The EMA/TGA will expend funds according to priorities established by the Planning Council, and for core medical services, support services, and administrative expenses only.

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[1] All statutory references are to the Public Health Service Act, unless otherwise specified.
[2] The six new TGAs (Baton Rouge, Columbus, Charlotte, Indianapolis, Memphis, and Nashville) are exempted from these requirements, but must provide a process for obtaining community input as described in **Section 2609(d)(1)(A)**.

Section 2604(c)

The EMA/TGA will expend not less than 75 percent of service dollars for core medical services, unless waived by the Secretary.

Pursuant to Section 2604(f)
The EMA/TGA will, for each of such populations in the eligible area use, from the grants made for the area under Section 2601(a) for a FY, expend not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS, unless a waiver from this provision is obtained.

Pursuant to Section 2604(g)
The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary**.**

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)
The EMA/TGA will expend no more than 10 percent of the grant on administrative costs, and in accordance with the legislative definition of administrative activities and the allocation of funds to entities and subcontractors, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)
The EMA/TGA will establish a CQM Program that meets HRSA requirements and that funding for this program shall not exceed the lesser of 5 percent of program funds or $3 million.

Pursuant to Section 2604(i)
The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)
With regard to the use of funds,

a. funds received under Part A of Title XXVI of the PHS Act will be used to supplement, not supplant, state funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease;
b. during the grant period, political subdivisions within the EMA/TGA will maintain at least their prior FY's level of expenditures for HIV related services for individuals with HIV disease;
c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV related services as required in the above paragraph; and
d. documentation of this MOE will be retained.

Pursuant to Section 2605(a)(3)
The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the healthcare system for the purpose of facilitating EIS for individuals diagnosed as being HIV positive.

Pursuant to Section 2605(a)(5)
The EMA/TGA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)
Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any state compensation program, insurance policy, or any Federal or state health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)
Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)
Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)
A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

Pursuant to Section 2605(a)(8)
The EMA/TGA has participated in the Statewide Coordinated Statement of Need (SCSN) process initiated by the state, and the services provided under the EMA/TGA's comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)
The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)
The EMA/TGA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

Pursuant to Section 2605(e)
The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)
Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684
No funds shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

______________________________________ Date_____________________

Signature