

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

HIV/AIDS Bureau  
Division of Metropolitan HIV/AIDS Programs

***Ryan White HIV/AIDS Program Part A  
HIV Emergency Relief Grant Program***

**Announcement Type:** Competing Continuation  
**Funding Opportunity Number:** HRSA-17-030

**Catalog of Federal Domestic Assistance (CFDA) No. 93.914**

**FUNDING OPPORTUNITY ANNOUNCEMENT**

Fiscal Year 2017

**Application Due Date: October 18, 2016**

*Ensure SAM.gov and Grants.gov registrations 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.*

**Issuance Date: August 15, 2016**

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Authority: Public Health Service Act, Sections 2601-2610, and 2693 (42 USC 300ff-11 – 300ff-20, and 300ff-121), 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 fiscal year (FY) 2017 Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program. The purpose of this 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 HIV/AIDS Program Part A HIV Emergency Relief Grant Program
Funding Opportunity Number:	HRSA-17-030
Due Date for Applications:	October 18, 2016
Anticipated Total Annual Available Funding:	\$618,322,901
Estimated Number and Type of Award(s):	Up to 52 grants
Estimated Award Amount:	Varies
Cost Sharing/Match Required:	No
Project Period:	March 1, 2017 through February 28, 2018; (one (1) year)
Eligible Applicants:	<p>RWHAP Part A recipients that are classified as an EMA or as a TGA and continue to meet the status as an eligible area as defined in statute are eligible to apply for these funds.</p> <p>[See <a href="#">Section III-1</a> of this funding opportunity announcement (FOA) for complete eligibility information.]</p>

### **Application Guide**

You (the applicant organization/agency) 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 FOA to do otherwise. A short video explaining the *Application Guide* is available at <http://www.hrsa.gov/grants/apply/applicationguide/>.

### **Technical Assistance**

All interested applicants are encouraged to participate in a technical assistance (TA) webinar for this funding opportunity. The purpose of this webinar is to assist potential applicants in preparing applications that address the requirements of this funding announcement. Participation in the pre-application TA webinar is optional.

The TA webinar is scheduled for September 13, 2016 from 2:00 – 4:00 P.M. Eastern Time.

Dial-in Phone Number: 1-800-619-7490; Passcode: 5798880#

To access the webinar online, go to the Adobe Connect URL:  
[https://hrsa.connectsolutions.com/dmhap\\_fy17\\_foa\\_ta/](https://hrsa.connectsolutions.com/dmhap_fy17_foa_ta/)

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# **I. Program Funding Opportunity Description**

## **1. Purpose**

This announcement solicits applications for the Ryan White HIV/AIDS Program (RWHAP) Part A HIV Emergency Relief Grant Program. The RWHAP Part A program 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. Based on an assessment of the services and gaps in the HIV care continuum within a jurisdiction or service area, planning bodies and recipients may identify specific service categories to fund. Funded service categories should facilitate improvements at specific stages of the HIV care continuum. Comprehensive HIV/AIDS care consists of core medical services and supportive services that enable individuals and families living with HIV/AIDS to access and remain in primary medical care to improve their medical outcomes.

RWHAP 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 low income people living with HIV/AIDS (PLWH) within the EMA/TGA and strengthen strategies to reach minority populations. The Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) requires EMAs/TGAs to collect data to support identification of need, for planning purposes, and to validate the use of RWHAP funding. A comprehensive application should reflect how those data were used to develop and expand the system of care in EMA/TGA jurisdictions. Needs assessments conducted by individual jurisdictions should also review/reference relevant needs assessments conducted by other HIV/AIDS programs, such as the HAB Integrated HIV Care and Prevention Plan, including the Statewide Coordinated Statement of Need (SCSN), HRSA's Bureau of Primary Health Care (BPHC), Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and the United States (U.S.) Department of Housing and Urban Development (HUD).

Ongoing CDC initiatives, as well as HAB's efforts with recipients 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 newly linked to care.

As of November 2014, the CDC estimates more than 1.2 million people are living with HIV and 1 in 7 (14 percent) are not aware of their HIV status. The ultimate goal within the U.S. 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.

**Important Notes:**

- Information on the RWHAP, the Affordable Care Act, and HAB Policy Clarification Notices is available online at <http://hab.hrsa.gov/affordablecareact/> and <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>.
- We continue to place emphasis on the HIV care continuum. We expect applicants to include a graph illustrating the HIV care continuum in the EMA/TGA and an explanation of how the HIV care continuum is utilized in the jurisdiction. Refer to Needs Assessment Section IV.2.ii.B for requirements.
- We updated the Unmet Need requirements in this funding opportunity announcement found in Section IV.2.ii.C.2. Please review carefully when preparing this section of the application.
- Policy Clarification Notice 16-02 (PCN 16-02) *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds* will be effective FY 2017. Therefore, please refer to PCN 16-02 for preparation of this application (<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>).

**The following information will assist in understanding and completing the FY 2017 grant application:**

- We require recipients to implement the RWHAP Part A National Monitoring Standards at the grant recipient and provider/subrecipient levels. HRSA developed and distributed guidelines outlining the responsibilities of HRSA, the grant recipient, and provider/subrecipient staff. The National Monitoring Standards are 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. We revised the WICY waiver reporting format to allow recipients to submit a waiver request and provide supporting data with the annual progress report.
- RWHAP Part A funds are subject to Section 2604(c) of the PHS Act which requires that not less than 75 percent of the funds remaining after reserving funds for administration and clinical quality management (CQM) be used to provide core medical services that are needed in the EMA/TGA for PLWH who are identified and eligible for care under the RWHAP. Core medical services are listed in section 2604(c)(3) of the PHS Act, and support services allowed under RWHAP Part A are limited to services that are needed for PLWH to achieve their medical outcomes, as defined by the RWHAP. The most recent service definitions can be found in the latest version of the National Monitoring Standards and in PCN 16-02, *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds* (<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>).
- 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 four months after the start of the grant award for

FY 2017. 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, recipients are advised that an FY 2017 RWHAP Part A core medical services waiver request must include funds awarded under the MAI. A waiver request that does not include MAI funds will not be considered. If submitting with the application, a core medical services waiver request should be included as **Attachment 9**.

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

## **2. Background**

This program is authorized by the PHS Act, Sections 2601-2610, and 2693 (42 USC 300ff-11– 300ff-20, and 300ff-121), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 11-87), (hereafter referred to as the RWHAP Part A). RWHAP 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 RWHAP 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 RWHAP Part A planning, priority setting and allocation processes. The legislation can be obtained at: <http://hab.hrsa.gov/about/hab/legislation.html>.

### ***National HIV/AIDS Strategy: Updated to 2020***

The National HIV/AIDS Strategy for the United States: Updated to 2020 (NHAS 2020 or Strategy) is a five-year plan that details principles, priorities, and actions to guide the national response to the HIV epidemic. To the extent possible, program activities should strive to support the primary goals of [NHAS 2020](#):

- 1) Reduce new HIV infections;
- 2) Increase access to care and optimize health outcomes for PLWH;
- 3) Reduce HIV-related health disparities and health inequities; and
- 4) Achieve a more coordinated national response to the HIV epidemic.

Updated in 2015, NHAS 2020 has fully integrated the objectives and recommendations of the [HIV Care Continuum Initiative](#) (see below) and the Federal Interagency Working Group on the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities. The Strategy also allows opportunities to refocus and strengthen the ongoing work in HIV prevention, care, and research.

Recipients should take action to align their organization's efforts, over the next five years, around the Strategy's four areas of critical focus:

- Widespread testing and linkage to care, enabling PLWH to access treatment early;
- Broad support for PLWH to remain engaged in comprehensive care, including support for treatment adherence;
- Universal viral suppression among PLWH; and
- Full access to comprehensive pre-exposure prophylaxis (PrEP) services for those to whom it is appropriate and desired, and support for medication adherence for those using PrEP.

More information on how recipients can support NHAS 2020, including the [Community Action Plan Framework](#), a tool to help recipients and other stakeholders in developing their own plans to implement NHAS 2020, can be found here: <https://aids.gov/federal-resources/national-hiv-aids-strategy/overview/>.

### ***HIV Care Continuum***

The HIV care continuum includes the diagnosis of HIV, linkage to HIV medical care, lifelong retention in HIV medical care, appropriate prescription of antiretroviral therapy (ART), and, ultimately, HIV viral load suppression. The HIV care continuum performance measures align with the [U.S. Department of Health and Human Services] [HHS Common HIV Core Indicators](#), approved by the HHS Secretary. RWHAP recipients and providers submit data through the Ryan White HIV/AIDS Program Services Report (RSR). HAB collects the data elements needed to produce the HHS Common HIV Core Indicators (Indicators); uses the data to calculate Indicators, across the entire RWHAP; and reports six of the seven Indicators to the HHS, Office of the Assistant Secretary for Health.

RWHAP recipients are encouraged to assess the outcomes of their programs along the HIV care continuum and work with their community and public health partners to improve outcomes, so that individuals diagnosed with HIV are linked to and engaged in care and started on ART as early as possible. HAB requests that recipients use the RWHAP [performance measures](#), at their local level, to assess the efficacy of their programs and to analyze and improve the gaps along the HIV care continuum.

### ***Integrated Planning***

In June 2015, HRSA's HAB and the CDC's Division of HIV/AIDS Prevention (DHAP) released a joint guidance for the Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN), a legislative requirement for RWHAP Parts A and B Recipients. This guidance is set forth for health departments and HIV planning groups funded by DHAP and HAB for the development of an



Integrated HIV Prevention and Care Plan. This new guidance format allows jurisdictions to submit one Integrated HIV Prevention and Care Plan, including the SCSN, to CDC and HRSA by September 30, 2016, covering calendar years 2017 – 2021. Submission of the Integrated HIV Prevention and Care Plan not only meets the legislative and programmatic requirements of CDC and HRSA, but also serves as a jurisdictional HIV/AIDS Strategy or roadmap. Please see <http://hab.hrsa.gov/manageyourgrant/hivpreventionplan062015.pdf>.

## **II. Award Information**

### **1. Type of Application and Award**

Type(s) of applications sought: Competing Continuation

Funding will be provided in the form of a grant.

### **2. Summary of Funding**

Approximately \$618,322,901 is expected to be available to fund fifty-two (52) recipients. The actual amount available will not be determined until enactment of the final FY 2017 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 March 1, 2017 through February 28, 2018 (one (1) year).

Effective December 26, 2014, all administrative and audit requirements and the cost principles that govern federal monies associated with this award are subject to the Uniform Guidance [2 CFR 200](#) as codified by HHS at [45 CFR 75](#), which supersede the previous administrative and audit requirements and cost principles that govern federal monies.

Please see [Policy Clarification Notice 15-01](#), *Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D* along with the [Frequently Asked Questions](#) for information regarding the statutory 10 percent limitation on administrative costs which includes indirect costs.

## **III. Eligibility Information**

### **1. Eligible Applicants**

Eligibility for RWHAP Part A grants depends in part on the number of confirmed AIDS cases within a statutorily specified “metropolitan area.” The Secretary of Health and Human Services uses the Office of Management and Budget’s (OMB’s) census-based definitions of a Metropolitan Statistical Area (MSA) in determining the geographic boundaries of a RWHAP metropolitan area. HHS relies on the OMB geographic boundaries that were in effect when a jurisdiction was initially funded under RWHAP Part A. For all newly eligible areas, the boundaries are based on current OMB MSA

boundary definitions.

Therefore, RWHAP Part A recipients that are classified as an EMA or as a TGA and continue to meet the status as an eligible area as defined in statute 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 five (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 five (5) calendar years for which such data are available. Additionally, for three consecutive years, recipients 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 five (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.4* will be considered non-responsive and will not be considered for funding under this announcement.

**Maintenance of Effort** – The recipient must agree to maintain EMA/TGA political subdivision expenditures for HIV-related core medical services and support services at a level equal to the FY preceding the FY for which the grant recipient is applying to receive a RWHAP Part A grant. See Section 2605(a)(1)(B) of the PHS Act. Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation and HRSA/HAB service definitions distributed to all recipients. RWHAP Part A recipients must document they have met the maintenance of effort (MOE) requirement (see **Attachment 12**).

NOTE: Multiple applications from an organization are not allowable.

If for any reason (including submitting to the wrong funding opportunity number or making corrections/updates), an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's **last** validated electronic submission, under the correct funding opportunity number, prior to the Grants.gov application due date as the final and only acceptable application.

# **IV. Application and Submission Information**

## **1. Address to Request Application Package**

HRSA **requires** applicants for this FOA to apply electronically through Grants.gov. You must download the SF-424 application package associated with this FOA following the directions provided at <http://www.grants.gov/applicants/apply-for-grants.html>.

## **2. Content and Form of Application Submission**

Section 4 of HRSA's [SF-424 Application Guide](#) provides instructions for the budget, budget narrative, 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. You are responsible for reading and complying with the instructions included in HRSA's [SF-424 Application Guide](#) except where instructed in the FOA to do otherwise.

See Section 8.5 of the *Application Guide* for the Application Completeness Checklist.

### **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 take appropriate measures to ensure the application 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.**

### **Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification**

- 1) The prospective recipient certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
- 2) Where the prospective recipient is unable to attest to any of the statements in this certification, such prospective recipient shall attach an explanation to this proposal.

See Section 4.1 ix. of HRSA's [SF-424 Application Guide](#) for additional information on this and other certifications.

### **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:

- general demographics of EMA/TGA;
- demographics of HIV/AIDS populations in the EMA/TGA;
- 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 MAI funds;
- description of the comprehensive system 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;
- number of years the EMA/TGA has received RWHAP Part A and MAI funding;
- changes to the RWHAP Part A program as a result of the changing health care landscape ; and
- challenges and/or successes implementing the HIV care continuum.

**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 must 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 PLWH in the RWHAP 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 RWHAP 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.*

*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.*

**A. Epidemiologic Overview**

**Note:** The Needs Section and the former Jurisdictional Profile have been aligned with Section 1. Epidemiologic Overview of the **Integrated HIV**

**Prevention and Care Plan.** Please insert the information developed for the Integrated Plan in response to the Integrated Plan instructions reiterated below. Also, please note that in future years, HAB intends to utilize the information in the Integrated Plan for the Epidemiologic Overview section.

An Epidemiologic Overview provides a description of the burden of HIV in the population of an area in terms of socio-demographic, geographic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, PLWH and persons at higher risk for infection. Understanding the populations affected by HIV provides the basis for setting priorities, identifying appropriate interventions and services, allocating HIV prevention and care resources, planning programs, and evaluating programs and policies. The overview should be based on available data for the jurisdiction.

The Epidemiologic Overview should focus on the most recent year for which data are available; when presenting trends, a minimum of five (5) years of data are recommended. Submit Demographic Table(s) as **Attachment 3**.

This section should:

- 1) Describe (map and narrative) the geographical region of the jurisdiction (i.e., Metropolitan Statistical Area/Metropolitan Division, Transitional Grant Area/Eligible Metropolitan Area, and States/Territories) with regard to communities affected by HIV infection.
- 2) Describe (table and/or graph with corresponding narrative) the socio-demographic characteristics of persons newly diagnosed, PLWH, and persons at higher risk for HIV infection in the service area, including the following, as available in the geographical region of the jurisdiction:
  - a) Demographic data (e.g., race, age, sex, transmission category, current gender identity)
  - b) Socioeconomic data (e.g., percentage of federal poverty level, income, education, health insurance status, etc.).
- 3) Describe (table, graph, and/or narrative) the burden of HIV in the service area using HIV surveillance data and the characteristics of the population living with HIV (i.e., number of PLWH, rates, trends, populations most affected, geographic concentrations, deaths, etc.).
- 4) Describe (table, graph, and/or narrative) the indicators of risk for HIV infection in the population covered by the service area using the following, as available in the jurisdiction:
  - a) Behavioral surveillance data, including databases, such as National HIV Behavioral Surveillance (NHBS) System, Youth Risk Behavioral Surveillance System (YRBSS), Behavioral Risk Factor Surveillance System (BRFSS) (e.g., patterns of, or deterrents to, HIV testing, substance use and needle sharing, sexual behavior, including

unprotected sex, sexual orientation and gender identity, health care-seeking behavior, trauma or intimate partner violence, and adherence to prescribed antiretroviral therapies)

- b) HIV surveillance data, including HIV testing program data (e.g., data from Early Identification of Individuals with HIV/AIDS for RWHAP Parts A and B recipients; CDC HIV testing data) and clinical data (e.g., CD4 and viral load results)
- c) RWHAP data (RSR; ADAP Data Report)
- d) Other relevant demographic data (i.e., Hepatitis B or C surveillance, STD surveillance, tuberculosis surveillance, and substance use data)
- e) Qualitative data (e.g., observations, interviews, discussion groups, focus groups, and analysis of social networks)
- f) Vital statistics data (e.g., state office of vital statistics, National Death Index, Social Security Death Master File)
- g) Other Relevant Program Data (e.g., Community Health Center program data).

## **B. FY 2017 HIV Care Continuum**

**Note:** We aligned the 2017 HIV Care Continuum with Section 1B: HIV Care Continuum of the **Integrated HIV Prevention and Care Plan**. Please insert the information developed for the Integrated Plan. Also, please note that in future years, HAB intends to utilize the information in the Integrated Plan for the HIV Care Continuum section.

The HIV care continuum is a model that is used by federal, state, and local agencies to identify issues and opportunities related to improving the delivery of services to PLWH across the entire HIV continuum of care. The HIV care continuum has five main “steps” or stages including: HIV diagnosis, linkage to care, retention in care, antiretroviral use, and viral suppression. State and local agencies should also use a model to identify issues and opportunities related to improving the delivery of services to high-risk, uninfected individuals, such as: HIV testing and linkage to appropriate prevention services, behavioral health, and social services.

The HIV care continuum provides a framework that depicts the series of stages a person with HIV engages in from initial diagnosis through their successful treatment with HIV medication. It shows the proportion of individuals living with HIV who are engaged at each stage. The HIV care continuum allows recipients and planning groups to measure progress and to direct HIV resources most effectively. The development and analysis of a comprehensive HIV care continuum involves collaboration across HIV care and treatment, prevention, and surveillance partners and will inform program planning Recipients and

planning groups need to develop an HIV care continuum for their jurisdiction as a part of the SCSN/needs assessment process.

To develop the HIV care continuum for the jurisdiction, it is essential to determine the approach that will be used. The CDC currently uses two different approaches to construct the HIV care continuum, the HIV prevalence-based continuum and the HIV diagnosed-based continuum; both are essential to monitor progress and identify key HIV prevention and care needs. The difference between the two approaches is the base number used to determine the percentage of the subsequent steps of the continuum.

The *prevalence-based* HIV care continuum shows each step of the continuum as a percentage of the total number of PLWH (i.e., HIV prevalence). HIV prevalence includes the number of people who have been diagnosed with HIV and the estimated number of those who have not been diagnosed with HIV. Thus, the prevalence-based approach may not be possible in all jurisdictions at this time, as some may not have reliable estimates of those with undiagnosed HIV; however, there are jurisdictions that are able to implement this approach.

The second approach is the *diagnosis-based* HIV care continuum. This approach shows each step of the continuum as a percentage of the number of PLWH who were diagnosed. The diagnosed-based continuum informs steps that can be taken to get individuals with HIV into care and get them to viral suppression. All recipients should have access to data needed to develop a diagnosed-based HIV care continuum.

Prior to developing the HIV care continuum, assess what approach is most feasible and will most effectively inform service delivery planning. In some cases it may be best to use both approaches as the information can provide a more complete assessment of the jurisdiction. A thorough discussion of the approach chosen and reason for using this approach should be included in the narrative for this section.

This section should:

- 1) Provide a graphic depiction and a descriptive narrative of the HIV care continuum of the jurisdiction using the most current calendar year data. The definitions of the numerator and the denominator must be clearly stated for each step. In addition to developing the HIV care continuum, include a discussion on the acquisition of data needed to develop it in the “Data: Use, Access, and Systems” section.

The steps of the *diagnosed-based* HIV care continuum using the HHS indicators are described below. If any updates are made to the HHS indicators or in the NHAS 2020 indicators that would impact the descriptions below, jurisdictions should use the most up-to-date indicator language. If using the *prevalence-based* approach, the continuum will have an additional first step that includes the undiagnosed HIV infected individuals in the jurisdiction and a different denominator for the other steps.

- a) **HIV-Diagnosed:** Diagnosed HIV prevalence in a jurisdiction; the known/reported cases of HIV infection, regardless of AIDS (stage 3 HIV infection) status; this number does not include the number of persons undiagnosed, and only includes the cumulative number of persons reported to the surveillance system through the end of a given year, minus the cumulative number of persons who were reported as having died.
  - b) **Linkage to Care:** The percentage of people diagnosed with HIV in a given calendar year that had one or more documented medical visits, viral load tests or CD4 tests within three (3) months after diagnosis; this measure has a different denominator than all other measures in the continuum. The denominator is the number diagnosed with HIV infection (regardless of AIDS status) in a given calendar year.
  - c) **Retained in Care:** The percentage of diagnosed individuals who had two or more documented medical visits, viral load tests or CD4 tests, performed at least three (3) months apart in the observed year.
  - d) **Antiretroviral Use:** The number of people receiving medical care and who have a documented antiretroviral therapy prescription in their medical records in the measurement year, if available.
  - e) **Viral Suppression:** The percentage of individuals whose most recent HIV viral load within the measurement year was less than 200 copies/mL.
- 2) Provide a narrative (and graphic, if available) description of disparities in engagement among key populations (e.g., young men who have sex with men (MSM), people who inject drugs (PWID), African-American heterosexual women, etc.) along the HIV care continuum.
- a) Describe how the HIV care continuum may be or is currently utilized in planning, prioritizing, targeting, and monitoring available resources in response to the needs of PLWH in the jurisdiction.
  - b) Describe how the HIV care continuum is utilized to improve engagement and outcomes at each stage of the HIV care continuum.
  - c) Describe how efforts to impact the HIV care continuum are evaluated in the jurisdiction.
  - d) Describe how information related to planning and evaluation of the HIV care continuum is disseminated in the jurisdiction.



### **C. 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 2017 plan and budget should be consistent with the discussion of demonstrated need. The Demonstrated Need section includes: Early Identification of Individuals with HIV/AIDS (EIIHA), Unmet Need, MAI, Special Populations, and Local Pharmaceutical Assistance Programs (LPAP).*

#### **1) 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 the most current year's data presented for persons at higher risk for infection in Section 1. Epidemiologic Overview of the Integrated HIV Prevention and Care Plan to respond to the EIIHA Plan section of this FOA.

#### **FY 2017 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 process or plan for linking people identified in the EIIHA data to both prevention (for HIV negative clients) and care services (for HIV positive clients). Include a description of community partners and other resources utilized to provide these services and any major collaboration with other programs and agencies including HIV prevention and surveillance programs.
- b) Describe the planned EMA/TGA EIIHA activities for FY 2017. Include the following information:
  - (1) The primary activities that will be undertaken, including system level interventions (e.g., routine testing in clinical settings, expanding partner services);
  - (2) Major collaborations with other programs and agencies, including HIV prevention and surveillance programs; and
  - (3) The anticipated outcomes of the program's overall EIIHA strategy.
- c) Describe how the proposed FY 2017 EIIHA Plan contributes to the goals of the NHAS 2020.
  - (1) Describe how the proposed FY 2017 EIIHA Plan contributes to improving health outcomes along the HIV care continuum.

- (2) List three (3) innovative approaches that are used in the program's EIIHA plan, to address barriers to assessing testing and treatment which contribute to the HIV care continuum.
  - (3) List the collaborations being pursued within the program's EIIHA plan within the community and with other public health stakeholders to strengthen outcomes across the HIV care continuum.
  - (4) How is the EIIHA data used to analyze or address any gaps along the HIV care continuum?
- d) Describe how the Unmet Need estimate based on the HIV care continuum and activities related to the Unmet Need population inform and relate to the EIIHA planned activities.
  - e) Describe how the EIIHA Plan for FY 2016 (e.g., process, activities and outcomes) influenced the development of the EIIHA Plan for FY 2017.
  - f) Describe any planned efforts to remove legal barriers, including state laws and regulations, to routine HIV testing.
  - g) Select three (3) distinct target populations for the FY 2017 EIIHA Plan. For each selected target population describe:
    - (1) Why the target population was chosen and how the epidemiological data, Unmet Need estimate data, or other data supports that decision;
    - (2) Specific challenges with or opportunities for working with the targeted population;
    - (3) The specific activities that will be utilized with the target population;
    - (4) 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);
    - (5) 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
    - (6) Planned outcomes that will be achieved for the target population as a result of implementing the EIIHA Plan activities.
  - h) Describe how EIIHA data are utilized in planning for services in the jurisdiction.
  - i) Describe how efforts to impact the EIIHA population are evaluated in the jurisdiction.
  - j) Describe how information related to planning and evaluation of the EIIHA data and plan are disseminated in the jurisdiction.

## 2) Unmet Need

Unmet Need is defined as the number of individuals with HIV in a jurisdiction who are **aware** of their HIV status and are *not in care*. Not in care has historically been defined as: no evidence of at least one of the following three components of HIV primary medical care during a specified 12 month time frame: 1) viral load (VL) testing, 2) CD4 count, or 3) provision of anti-retroviral therapy (ART). By addressing unmet need in EMAs and TGAs through measurement, developing strategies to decrease unmet need and implementing these strategies, the RWHAP directly contributes to NHAS 2020 Goal 2: *Increasing access to care and improving health outcomes for PLWH* and Goal 3: *Reducing HIV-related disparities and health inequities*.

Similar to FY 2016, and for this FOA, the Unmet Need Section will require recipients to compute unmet need estimates two ways (**Attachment 4**):

- Current methodology using the Unmet Need Framework to calculate Unmet Need for FY 2017 using CY 2015 data.
- New methodology using the HIV Care Continuum Framework to calculate an Unmet Need estimate for FY 2017 using CY 2015 data.

The HIV/AIDS Bureau continues to consider the best approach to developing a sound framework and methodology for estimating unmet need. We will continue to work on updating and revising the framework based on your responses to this funding announcement, with the goal of developing one updated framework for future years. From our analysis of the responses to the unmet need section of the FY 2016 funding opportunity announcement (FOA) it appears that recipients were able to develop an estimate of unmet need based on the HIV Care Continuum Framework (new methodology). However, the majority of jurisdictions had a higher unmet need estimate based on this method when compared to current methodology. This may have resulted from a more stringent “in care” definition required by the new methodology and its inability to account for stable/virally-suppressed individuals not requiring multiple medical visits. To continue our examination and understanding of the two methods for estimating unmet need, applicants are asked again to provide two estimates of unmet need based on the old and new methodologies, and compare and contrast the results from each method.

### **Current Methodology: Unmet Need Framework Estimate**

- a) Based on the estimate developed for FY 2017 from this framework, provide an Unmet Need Narrative description of the following:
  - (1) Estimation methods: The approach used to develop the Unmet Need estimates, reasons for choosing this approach, revisions or updates from the FY 2016 estimates, any limitations, and any cross program collaboration that occurred.

- (2) **Assessment of Unmet Need:** Summarize the findings or results of studies on the demographics of populations and special populations that are included in the Unmet Need estimate. The Summary should include the following:
- (a) The demographics and geographic location of people who are aware of their HIV status but are not in care;
  - (b) A description of the Unmet Need trends over the past five years; and
  - (c) An assessment of service needs, gaps, and barriers to care for people not in care.

**New Methodology: Unmet Need Estimate based on the HIV Care Continuum Framework**

An estimate of Unmet Need can also be derived by using data from the HIV Care Continuum Framework. On the HIV care continuum, people who are HIV positive and know their status are referred to as *Diagnosed*, the known/reported cases of HIV infection, regardless of AIDS (stage 3 HIV infection) status. The number of people who are “in care” aligns with the third stage of the HIV care continuum, *Retained in Care*. Retained in Care is the number of diagnosed individuals who had two or more documented medical visits, VL or CD4 tests performed at least three months apart in the calendar year. The Unmet Need estimate is then calculated by subtracting the number of *Retained in Care* from the number of *Diagnosed*. Use this method to derive an estimate of unmet need for your area using CY 2015 data.

***Note: The definition of Retained in Care used in this estimate is taken from the CDC and most closely mirrors the number of people in care described in the previous Unmet Need Framework.***

Compare and contrast the FY 2017 unmet need estimates derived from the Current Unmet Need Framework and the new HIV Care Continuum Framework. Specifically:

- a) Describe any variances in the unmet need estimates for FY 2017 resulting from use of the current versus new methodology.
- b) Compare the unmet estimate derived from the HIV Care Continuum in FY 2016 (that used CY 2014 data) to the unmet need estimate derived for FY 2017 (using CY 2015 data). Describe any changes in the Unmet Need Estimate for FY 2017. If no changes are identified, provide an explanation as to why.
- c) Explain and describe the data used to determine Unmet Need using the HIV Care Continuum framework methodology.
- d) If the definition of Retained in Care used to calculate the unmet need estimate differs from the HIV Care Continuum definition, provide the

definition utilized in the jurisdiction to determine the unmet need estimate.

- e) What are the challenges of using the Retained in Care measure to calculate Unmet Need? What adjustments would you make or suggest to better reflect the true unmet need in your jurisdiction? Have you had any success or improvements in addressing these challenges?
- f) Explain how the estimate derived from the HIV Care Continuum Framework impacts your approach to the unmet need estimate:
  - (1) Does it require your area to revise or modify its strategy for identifying the unmet need populations;
  - (2) What are the characteristics of the population identified;
  - (3) What are the strategies used to link these populations back into care; and eliminate barriers to improving access to care.
- g) Describe how the Unmet Need estimate is utilized in planning for services in the jurisdiction.
- h) How are the strategies/interventions implemented to reduce unmet need evaluated? Are programs evaluated to determine their impact on the reduction of unmet need?
- i) Describe how information related to planning and evaluation of the Unmet Need estimate is disseminated throughout the jurisdiction.

### **3) Service Gaps**

*The purpose of this section is to describe service gaps within the EMA/TGA. Service gaps are defined as all service needs not currently being met for all PLWH except the need for primary medical care. Using information based on gaps identified along the HIV care continuum and any other available data in the jurisdiction (i.e., needs assessment, surveys, resource inventories, and community input), identify and describe HIV care services that are needed in the jurisdiction.*

- a) Identify service gaps within the jurisdiction;
- b) Describe the method used to prioritize the service gaps; and
- c) Describe how these service gaps will be addressed with FY 2017 RWHAP Part A funding.

### **4) Minority AIDS Initiative**

*Under RWHAP Part A, MAI formula funding provides 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 RWHAP 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 RWHAP Part A recipients 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 this application should be targeted with MAI funds.*

*Like the RWHAP, the goal of the MAI is viral suppression. The MAI program’s mission is to address health disparities and health inequities among minority communities. MAI funds are to be used to deliver services designed to address the unique barriers and challenges faced by hard-to-reach, disproportionately impacted minorities within the EMA. The services have to be consistent with the epidemiologic data, needs of that community, and culturally appropriate. This requires the use of population-tailored, innovative approaches or interventions that differ from usual service methodologies and that specifically address the unique needs of targeted sub-groups. To this end, MAI is in concert with the NHAS 2020 goal of Reducing HIV-Related Disparities and Health Inequities, which includes:*

- *Reducing HIV-related mortality in communities at high risk for HIV infection.*
  - *Adopting community-level approaches to reduce HIV infection in high risk communities.*
  - *Reducing stigma and discrimination against PLWH.*
- a) Based on the demographic characteristics presented in the Epidemiologic Overview, select the most impacted minority populations (maximum 3). Create a care continuum illustrating any significant health disparities experienced by these populations. Special attention should be paid to populations where specific sub-populations may experience the greatest health disparities, for example, young black men who have sex with men (YBMSM) ages 13 - 24.
- b) For each MAI population identified:
- (1) Describe the planning process for determining the needs of the MAI populations identified in the Epidemiologic Overview.
  - (2) Describe specific culturally appropriate, population-tailored interventions and community partnerships utilized to increase bars on the HIV care continuum. Explain how these unique activities differ from other RWHAP Part A services.
  - (3) Describe the impact of these specific interventions and how it will be evaluated and disseminated to stakeholders.

## **5) Special Populations and Complexity of Providing Care**

*RWHAP funds are intended to supplement funding for local health care*

*systems overburdened by the increasing cost of providing health care services to special populations. In addition to HIV/AIDS, public health care 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.*

Provide a brief narrative description of the following:

- a) Emerging Communities – New/emerging populations not reported on in last year's application where significant changes were noted in service delivery in the EMA/TGA (i.e., youth, women, young MSM, black MSM, etc.). Include information on how emerging populations were identified, unique challenges, and estimated costs to the Part A program, (if applicable).
- b) Under-represented Populations – Populations of PLWH in the EMA/TGA that are RWHAP eligible and under-represented in the RWHAP funded system of HIV/AIDS primary medical care.
- c) Co-morbidities - Present the profile of PLWH with co-morbidities in the EMA/TGA using quantitative evidence (in table format as **Attachment 5**) and document data sources. **The table must include:**
  - (1) Hepatitis C Virus
  - (2) STI rates
  - (3) Prevalence of homelessness
  - (4) Formerly incarcerated
  - (5) Mental illness
  - (6) Substance abuse
- d) 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. Compare the rates in the general EMA/TGA population with the rates among PLWH in the EMA/TGA.

**6) AIDS Pharmaceutical Assistance (i.e., Local Pharmaceutical Assistance Program) – Not Scored**

*This section must be completed by all jurisdictions that have included funding for a Local Pharmaceutical Assistance Program (LPAP) in the application. The purpose of this section is to describe the need for an LPAP, including a description of the systems and activities required to effectively operate an LPAP. When a jurisdiction determines there is a need for medication assistance and decides to allocate funds to the LPAP service category, it must demonstrate that the decision was based on information identified through a formal needs assessment process. The needs assessment must determine that the State/Territory's AIDS Drug Assistance Program (ADAP) does not adequately address the medication assistance needs of clients in the jurisdiction (e.g., existence of an ADAP waiting list, restrictive ADAP financial eligibility criteria, or a limited ADAP formulary).*

*The needs assessment must also demonstrate that other resources are inadequate to meet the medication needs of clients residing in the jurisdiction.*

*The National Monitoring Standards, which were updated after an LPAP [letter of clarification](#), was sent August 29, 2013, outlines the systemic requirements necessary to comply with the service category definition. Implementation of an LPAP involves the development of a drug distribution system that includes, but is not limited to: client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum every six months; an LPAP advisory board; uniform benefits for all enrolled clients; compliance with RWHAP requirement of payer of last resort; and a drug formulary approved by the local advisory committee/board. **An LPAP may not be used to provide short-term or emergency medication assistance.** Please refer to the National Monitoring Standards and PCN 16-02 for a complete list of LPAP requirements.*

If the program is planning to use funds for an LPAP, describe the following:

- a) The need for an LPAP in detail; include how the ADAP, other RWHAP funded service categories, and other resources (e.g., pharmaceutical assistance programs, patient assistance programs, local/state funded medication assistance programs) are failing to meet the jurisdiction's medication needs.
- b) The component of the medication need that the LPAP will fill.
- c) How the LPAP will be coordinated with the ADAP.
- d) The client enrollment and eligibility process including how payer of last resort is ensured.
- e) The existing LPAP advisory board composition; if this is a new service category, describe the process and timeframe for development of the LPAP advisory board.
- f) How the recipient ensures that the LPAP follows the most recent [HHS HIV/AIDS Treatment Guidelines](#).
- g) The mechanism to ensure "best price" for medications, (e.g., 340B Drug Pricing Program and/or Prime Vendor Program).

- *METHODOLOGY -- Corresponds to Section V's Review Criteria #2 and #4*

#### **A. Impact of Funding**

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



**1) Impact and Response to Reduction in RWHAP Formula Funding**

If the EMA/TGA experienced a reduction in RWHAP Part A formula funding last year, provide a narrative that addresses both the impact and response to the funding reduction, as follows:

- a) Impact: The specific services that were eliminated or reduced, and by how much; and
- b) Response: Any cost containment measures implemented, (e.g., waiting lists, client cost sharing, or other measures); PC 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.

**2) Impact of the Changing Health Care Landscape**

*Through the Affordable Care Act, health insurance coverage options have been expanded for PLWH. These changes may affect health insurance coverage options in the jurisdiction, as well as RWHAP 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 health care coverage are expeditiously enrolled in any coverage for which they may qualify.*

- a) **Uninsured and poverty:** Provide, in a table format, current estimates on PLWH who are uninsured and living in poverty in your jurisdiction. Include the following information as available:
  - (1) The number and percentage of persons who are enrolled in Medicaid, Medicare, and marketplace exchanges;
  - (2) The number and percentage of persons without private or public health care coverage; (i.e., those without Medicaid, Medicare, or other public coverage); and
  - (3) The number and percentage of persons living at or below 138 percent and 400 percent of the 2015 FPL. Also include the percentage of FPL used to determine RWHAP eligibility in the jurisdiction.
- b) **Impact of health insurance expansion:** Describe the outcomes (e.g., successes and challenges) of the changing health care landscape and insurance expansion during the most recent Marketplace enrollment period (e.g., Medicaid and/or private marketplace, etc.) on the Part A either on a local level or in conjunction with the state. Provide information for each section and provide examples as appropriate. Describe how the changing health care landscape affects:
  - (1) Service provision and the complexity of providing care to PLWH in the EMA/TGA.
  - (2) Changes in allocations, including activities related to health insurance premium assistance.

- (3) Costs including service costs, cost-sharing, cost-savings, etc.
- c) **Outreach and enrollment:** Describe efforts during the most recent Marketplace enrollment period and provide examples as available on the following:
- (1) How outreach and enrollment efforts were conducted in your area to RWHAP Part A clients (e.g. who did it, how long, etc.). Refer to HAB PCNs 13-01, [Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by Ryan White HIV/AIDS Program](#), and 13-04, [Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program](#) (<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>).
  - (2) Coordination efforts with other agencies and community partners.
  - (3) List up to three major challenges to outreach and enrollment efforts.
  - (4) List up to three major facilitators to outreach and enrollment efforts.
- d) **Marketplace options:** Provide an overall description of the current plans available to PLWH.
- (1) Specify how the plans affect provider accessibility. List no more than three challenges experienced.
  - (2) Specify how the plans affect care and medications for PLWH. List no more than three challenges experienced.

### 3) 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 RWHAP 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 PLWH. Activities that facilitate collaboration and/or develop a joint planning body to address prevention and care are supported by both HRSA and CDC. Community engagement is an essential component for planning comprehensive, effective HIV prevention and care programs in the U. S. Please refer to the joint [HRSA/CDC letter dated February 24, 2014](#), for more information on integrated planning.*

*The composition of the 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, PCs/planning bodies are encouraged to educate members about service issues related to the prevention of domestic and sexual violence. PCs/planning bodies should also consider recruiting members who are knowledgeable about these issues.*

**a) Description of the Community Input Process**

- (1) Describe the overall structure of the community input process and how this process provides input into the legislatively required Planning Council/Planning Body priority setting and resource allocation process for the jurisdiction; include a detailed description of this priority setting and allocations process, and an explanation of how this planning is focused on and contributes to health outcomes along the HIV care continuum.
- (2) Describe the specific prioritization and allocation process of the Planning Council/Planning Body and include the following:
  - (a) How the needs of the following were considered: PLWH not retained 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 the input of the community was considered and whether it adequately addressed any funding increases or decreases in the RWHAP Part A award;
  - (d) How MAI funding was considered during the planning process to enhance services to minority populations;
  - (e) 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 HIV/AIDS care in the EMA/TGA;
  - (f) How changes and trends in HIV/AIDS epidemiology data were used in the planning and allocation process;
  - (g) How cost data were used in making funding allocation decisions;
  - (h) How data from other federally funded HIV/AIDS programs were used in developing priorities (refer to **Attachment 7** described below);
  - (i) How anticipated changes, due to the changing health care landscape, were considered in developing priorities; and
  - (j) What efforts have or will be taken to integrate prevention and care planning at the RWHAP Part A level, in order to maximally provide high-quality care and treatment and help prevent new infections in the jurisdiction.

**b) 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 6**. The letter must address the following:

- (1) That FY 2016 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 2016 Conditions of Award relative to the PC or planning

body have been addressed;

- (3) That FY 2016 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 ongoing, and at least 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 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.

**c) Coordination of Services and Funding Streams**

*RWHAP 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. RWHAP Part A planning efforts should also consider service needs not currently being met (defined as service gaps). Planning should also be coordinated with all other public funding for HIV/AIDS to: (1) ensure that RWHAP funds are the payer of last resort, (2) maximize the number and accessibility of services available, and (3) reduce any duplication.*

**Note:** The Coordination of Services and Funding Streams has been aligned with Section 1C. Financial and Human Resources Inventory of the **Integrated HIV Prevention and Care Plan**. The HIV Workforce Capacity section of the Human Resources Inventory should not be included in this section of the FOA. Please insert the following information from the Integrated Plan. Also, please note that in future years, the plan is to utilize the information in the Integrated Plan for the Coordination of Services and Funding Streams section.

**(1) Financial and Human Resources Inventory (excluding the HIV Workforce Capacity section)**

This section provides an inventory of the financial and service delivery provider resources available in a jurisdiction to meet the HIV prevention, care, and treatment needs of its population as well as resource gaps. By identifying existing resources, deficits in resources will be more evident and communities can make better informed planning decisions.

This section should:

- (a) Provide, in a table format as **Attachment 7**, a jurisdictional HIV resources inventory, that includes: (1) public and private funding sources for HIV prevention, care, and treatment services in the jurisdiction; (2) the dollar amount and the percentage of the total

available funds in fiscal year (FY) 2016 for each funding source; (3) how the resources are being used (i.e., services delivered); and (4) which component(s) of HIV prevention programming and/or steps of the HIV care continuum is/are impacted. At a minimum, the table should contain the following information:

- i. Funding Sources (e.g., RWHAP Parts A-F, including Special Projects of National Significance (SPNS) and the AIDS Education and Training Centers (AETC) Program, CDC HIV Prevention and Surveillance Programs, MAI, SAMHSA, HUD/HOPWA, Medicaid expenditures, HRSA/Bureau of Primary of Health Care, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, Administration for Children and Families, and other public and private funding sources);
  - ii. Funding Amount (\$);
  - iii. Funded Service Provider Agencies;
  - iv. Services Delivered; and
  - v. HIV Care Continuum Step(s) Impacted (*please see Section I. B. HIV Care Continuum in the Integrated Plan*)
- (b) Provide a narrative description of how different funding sources interact to ensure continuity of HIV prevention, care, and treatment services in the jurisdiction.
- (c) Provide a narrative description identifying any needed resources and/or services in the jurisdiction which are not being provided, and steps taken to secure them.

▪ **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 service provision during FY 2017. It should describe how RWHAP 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.*

**A. Funding for Core and Support Services**

*RWHAP Part A funds are subject to Section 2604(c) of the PHS Act which requires that recipients expend 75 percent of RWHAP Part A funds, **remaining after reserving funds for administration and CQM**, on core medical services that are needed in the EMA/TGA for individuals with HIV/AIDS who are identified and eligible under the RWHAP.*

**1) FY 2017 Service Category Plan**

*The Service Category Plan utilizes core medical and support service categories that are prioritized and funded by the PC or through local community planning processes. The plan consists of both RWHAP Part A and MAI funds. **Please indicate if a core medical services waiver for FY***

***17 was submitted (either approved or pending) prior to submission of this application. Allocations in the Service Category Plan should match the submitted waiver.***

**a) Service Category Plan Table**

The service category table illustrates how RWHAP Part A and MAI core medical and support services are funded in the EMA/TGA. It is comprised of service categories, priority number, funding amount, unduplicated clients served, service unit definition, service units, and target populations (MAI only) for FYs 2015, 2016, and 2017. For every service category funded by RWHAP Part A in the jurisdiction, provide in table format the following (submit as **Attachment 8**):

- (1) FY 2015 funded service categories with priority number, actual funding expended, actual number of unduplicated clients served, service unit definition, and the number of service units provided for each category. Include total dollar amounts and percentages of expenditures for core and support services. Do not include carryover dollars. Repeat the table for MAI services and include a column for target populations.
- (2) FY 2016 service categories with priority number, allocated funding amount, and number of projected unduplicated clients to be served per the FY 2016 Implementation Plan submitted with the FY 2016 Program Terms Report, service unit definitions, and service units. Include total dollar amounts and percentages of expenditures for core and support services. Repeat the table for MAI services and include a column for target populations.
- (3) FY 2017 service categories with priority number, anticipated funding amount, anticipated number of unduplicated clients to be served, service unit definitions, and service units. Include total dollar amounts and percentages of expenditures for core and support services. Repeat the table for MAI services and include a column for target populations.

**b) Service Category Plan Narrative**

Based upon the FY 2017 Service Category Plan, provide a narrative that describes the following:

- (1) Identify any prioritized core medical services that will not be funded with FY 2017 RWHAP funds and how these services will be delivered in the EMA/TGA (e.g., services funded by Medicaid, Medicaid expansion, Affordable Care Act, Marketplace, Children's Health Insurance Program (CHIP), etc.);
- (2) How activities described in the Plan will promote parity of HIV services throughout the EMA/TGA. Parity of services should be addressed in terms of geographic location of services, quality, and number of available services;
- (3) How planned activities assure that services delivered by providers are culturally and linguistically appropriate to the populations served within the EMA/TGA;

- (4) Describe factors that contributed to changes in funding within service categories (e.g., changes in the health care landscape, increase/decrease in RWHAP Part A award, changes in provider capacity, changes in available resources, etc.);
- (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 changes to service categories are linked to needs assessments or updates, including Unmet Need or new initiatives.

**c) Core Medical Services Waiver (if applicable – not scored)**

Applicants must provide a separate Allocation Table that is reflective of the results of the priority setting and resource allocation process, **only if a Core Medical Services waiver is submitted with this application.** The Allocation Table must be consistent with the waiver request. The Allocation Table and the Core Medical Services Waiver request should be included as **Attachment 9**. If a Core Medical Services Waiver is not submitted with this application, do not include an **Attachment 9**.

**B. FY 2017 HIV Care Continuum Work Plan**

The HIV care continuum work plan depicts how RWHAP service categories will be used to improve indicators along the HIV care continuum. The work plan is comprised of the stages of the HIV care continuum, baseline indicators for each stage, the desired target outcome to be achieved during the current fiscal year, and the RWHAP-funded service categories to help support achieving the desired outcome. The baseline indicator reported in the HIV care continuum work plan should be consistent with the data reported in the HIV care continuum section of this application. The target outcome must be developed based on one of the seven common indicators for HHS funded HIV-programs and services, or one of the HAB Core Performance Measures that correspond to each stage of the HIV care continuum. The baseline and target indicators must be expressed as a numerator and denominator as well as a percentage. The service categories funded by the RWHAP Part A program that will aid in achieving the desired target outcome are to be listed in the last column of the HIV care continuum work plan. Submit as **Attachment 10**.

▪ **RESOLUTION OF CHALLENGES -- Corresponds to Section V's Review Criterion #2**

Describe the approaches that will be used to resolve the challenges and barriers identified throughout this application in the larger context of implementing the RWHAP Part A Program (e.g., changes in the health care landscape, community engagement, etc.). Discuss challenges that have been encountered in integrating the HIV care continuum into planning and implementing the RWHAP Part A program, and approaches that will be used to resolve such challenges. In lieu of narrative for this section, include a table with the following headers: Challenges, Resolutions, Outcomes and Current Status for implementing both the RWHAP Part A Program overall and the HIV care continuum.

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

#### **A. Clinical Quality Management (CQM)**

[Title XXVI of the PHS Act](#) RWHAP Parts A – D (§§ 2604(h)(5), 2618(b)(3)(E), 2664(g)(5), and 2671(f)(2)) requires 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 Public Health Service guidelines, (otherwise known as the HHS guidelines) for the treatment of HIV disease and related opportunistic infections; and
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to, and quality of HIV services.

The CQM requirement applies directly to Parts A – D recipients; it is the responsibility of the recipient to work directly with their subrecipients to implement, monitor and provide any needed data on the CQM program. A CQM program is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction. To be effective, a CQM program requires:

- Specific aims based in health outcomes;
- Support by identified leadership;
- Accountability for CQM activities;
- Dedicated resources; and
- Use of data and measurable outcomes to determine progress and make improvements to achieve the aims cited above.

CQM activities should be continuous and fit within and support the framework of grant administration functions. The CQM program should be in relative size and scope of the grant award. Recipients are strongly encouraged to use the NHAS 2020 to frame CQM activities and goals.

CQM programs have three main components:

- **Infrastructure** is needed to plan, implement, and evaluate CQM program activities.
- **Performance measurement** is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes on an individual or population level, and patient satisfaction.
- **Quality improvement** entails the development and implementation of activities to make changes to the program in response to the performance data results.

More information about the HRSA RWHAP expectations for CQM programs can be found in a [policy clarification notice](#) 15-02 released in September 2015. [Frequently asked questions](#) were released in December 2015.



*Resources:*

[15-02 Clinical Quality Management Policy Clarification Notice](#) and Frequently Asked Questions

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

*HIV/AIDS Bureau Performance Measures:*

<http://hab.hrsa.gov/deliverhivaidscares/habperformmeasures.html>

*Department of Health and Human Services HIV/AIDS Medical Practice Guidelines:*

<https://aidsinfo.nih.gov/guidelines>

*HIV/AIDS Bureau Part A Monitoring Standards (Part A specific, Universal Monitoring Standards, and Frequently Asked Questions):*

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

*HIV/AIDS Bureau Part A Manual:*

<http://hab.hrsa.gov/manageyourgrant/files/happartamanual2013.pdf>

**1) Description of CQM Program Infrastructure:**

- a) List the number of staff FTEs assigned to CQM.
- b) Describe the CQM program staff roles and responsibilities.
- c) Name any entity(s) under contract or to be contracted with for the CQM program, and activities the contractor has/will provide.
- d) Describe efforts to coordinate CQM activities with other RWHAP recipients in the jurisdiction.

**2) Description of CQM Program Performance Measures:**

- (a) List the performance measure(s) for the upcoming grant year for all funded service category(s).
- (b) Describe how often performance measure data are collected for each funded service category including from subrecipients (if applicable).
- (c) Summarize the performance measure data collected for outpatient ambulatory health services and medical case management from the last grant year or calendar year, including any trending data.
- (d) Describe how performance measure data are analyzed to evaluate for disparities in care, and actions taken in the last grant year to eliminate disparities.
- (e) Describe how stakeholders, including subrecipients, consumers, and other RWHAP recipients in the jurisdiction and PC/body contribute to the selection of performance measures and receive information about

performance measure data.

**3) Description of CQM Program Quality Improvement:**

- (a) Describe the quality improvement approach or methodology (e.g., model for improvement, Lean Six Sigma, etc.) implemented by the recipient. Describe the processes for identifying priorities for quality improvement. Provide examples of specific quality improvement projects undertaken in the last grant year. Describe the process to monitor and support subrecipient engagement in quality improvement projects.
- (b) Describe quality improvement activities implemented by the recipient in the last grant year aimed at improving HIV viral suppression within the jurisdiction. Describe how subrecipients were involved in improving HIV viral suppression.
- (c) Discuss how the CQM data have been used to improve and/or change service delivery in the jurisdiction, including strategic long-range service delivery planning.
- (d) Describe how stakeholders including subrecipients, consumers, other RWHAP recipients in service area, and PC/body contribute to the selection of quality improvement activities undertaken by the recipient.

**4) Data for Program Reporting**

- (a) Name and describe the information/ data system(s) within the EMA/TGA used for data collection and reporting operations.
- (b) Describe the recipient's current client level data collection capabilities included in the RSR. Include the percentage of subrecipients that were able to report CY 2015 client level data. Describe efforts to increase data completeness and validity.

▪ **ORGANIZATIONAL INFORMATION -- Corresponds to Section V's Review Criterion #5**

**A. Grant Administration**

*The purpose of this section is to demonstrate the extent to which the CEO or designee in the EMA/TGA has met the legislative requirements to disburse funds quickly, closely monitor their use, and ensure the RWHAP is the payer of last resort. The RWHAP stresses the importance of timely obligation of RWHAP funds. Timely obligation of RWHAP 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 RWHAP Part A formula and supplemental unobligated balance (UOB) requirement as well as [Policy Notice 12-02](#). 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:*

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

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

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

**Supplemental Funds**

*Under the RWHAP legislation, the HHS Secretary has flexibility regarding supplemental funds. Recipients may not submit a carryover request for supplemental funds, which would permit those funds to be added to the subsequent period of performance; instead, UOB supplemental funds are subject to an offset. UOB supplemental funds do not make a grant recipient ineligible for a future year supplemental award.*

**1) Program Organization**

- a) Provide a description of how RWHAP 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 11**. The narrative should describe: the local agency responsible for the grant and identify the entity responsible for administering the RWHAP 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 RWHAP Part A and MAI services/activities.
- b) Provide a descriptive narrative of the process and mechanisms, including data collection to ensure that providers funded through multiple RWHAP 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.

**2) Grant Recipient Accountability**

*HRSA/HAB holds recipients accountable for the expenditure of funds awarded under RWHAP Part A and expects recipients to monitor subrecipient fiscal and programmatic compliance. Recipients are also required to have on file a copy of each subrecipient's procurement document (contracts), and fiscal, program, and site visit reports. Also see*

*the requirements outline in the HHS Uniform Guidance - [Subrecipient Monitoring and Management](#) (45 CFR §75.351 and 352).*

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

- (1) An update on the grant recipient's implementation of the National Monitoring Standards;
- (2) The process used to conduct subrecipient monitoring;
- (3) The total number of subrecipients funded in FY 2016; the frequency of monitoring site visits (both programmatic and fiscal) and the generation of reports during a program year; the number and percentage of subrecipients that have received a fiscal and/or programmatic monitoring site visit to date, and the total number planned for the FY 2016 period of performance;
- (4) The process and timeline for corrective actions when a fiscal or programmatic-related concern is identified; any improper charges or other findings in FY 2016 to date and a summary of the corrective actions planned or taken to address these findings; and
- (5) The number of subrecipients that have received technical assistance (TA) for FY 2016, to date (types of TA, scope, and timeline).

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

- (1) 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 subrecipient expenditures, UOB, and program income);
- (2) The process used to separately track formula, supplemental, MAI, and carry over funds, including information on the data systems utilized;
- (3) The process used to ensure timely monitoring and redistribution of unexpended funds;
- (4) The process for reviewing subrecipient compliance with the single audit requirement in [Subpart F of the HHS Uniform Guidance](#) (45 CFR §75.500 – 520);
- (5) If there were findings in any subrecipient single audit reports, describe what the grant recipient has done to ensure that subrecipients have taken appropriate corrective action. Corrective actions may include, but are not limited to, HRSA/HAB sponsored TA and training requests from the grant recipient of record; and
- (6) The process for reimbursing subrecipients, from the time a voucher/invoice is received to payment.

**3) Administrative Assessment**

*The RWHAP mandates that EMA/TGA PCs assess the efficiency of the administrative mechanism to rapidly allocate funds to the areas of greatest need within the EMA/TGA.*

Provide a narrative that describes the results of the PC's assessment of the administrative mechanism in terms of:

- a) Assessment of grant recipient 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 grant recipients' response to those deficiencies, and what is the current status of the grant recipient's corrective actions?

#### **4) Third Party Reimbursement**

*The RWHAP is the payer of last resort and you must vigorously pursue alternate sources of payments. You must certify eligibility every 12 months/annually and recertify eligibility at least every six (6) months (see PCN 13-02, Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements, <http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>). Recipients and subrecipients are required to use effective strategies to coordinate between RWHAP 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 Children's Health Insurance Programs (CHIP), Medicare, including Medicare Part D, and private insurance, including new options available under the health insurance Marketplace. Subrecipients providing Medicaid eligible services must be Medicaid certified.*

Provide a narrative that describes the following:

- a) The process used by recipients to ensure that subrecipients 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 grant recipient monitors the appropriate tracking and use of any program income at both the recipient and subrecipient level.

#### **E. Maintenance of Effort (MOE)**

*The RWHAP legislation requires RWHAP Part A recipients 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 FY preceding the FY for which the grant recipient is applying to receive a RWHAP Part A grant. 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 recipients. RWHAP Part A recipients must document that they have met the MOE requirement.*

You must submit the following information as **Attachment 12**:

- 1) A table that identifies the MOE budget elements and the amount of expenditures related to HIV/AIDS core medical and support services for the two most recently completed fiscal years prior to the application deadline;
- 2) Based on the prior fiscal year MOE table reflecting actual expenditures, include a narrative that demonstrates MOE will be maintained in the current fiscal year; and
- 3) A description of the process and elements used to determine the amount of expenditures in the MOE calculations.

<b>NARRATIVE GUIDANCE</b>	
In order to ensure that the Review Criteria are fully addressed, this table provides a crosswalk between the narrative language and where each section falls within the review criteria.	
<b><u>Narrative Section</u></b>	<b><u>Review Criteria</u></b>
Introduction	(1) Need
Needs Assessment <ul style="list-style-type: none"> <li>• Epidemiologic Overview</li> <li>• FY 17 HIV Care Continuum</li> <li>• Early Intervention of Individuals with HIV/AIDS</li> <li>• Unmet Need</li> <li>• Service Gaps</li> <li>• Minority AIDS Initiative</li> <li>• Special Populations and Complexity of Providing Care</li> </ul>	(1) Need
Methodology <ul style="list-style-type: none"> <li>• Impact of Funding</li> <li>• Impact of Changing Health Care Landscape</li> <li>• Planning and Resource Allocation</li> </ul>	(2) Response and (4) Impact
Work Plan <ul style="list-style-type: none"> <li>• Funding for Core and Support Services</li> <li>• FY 17 HIV Care Continuum Work Plan</li> </ul>	(2) Response
Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity <ul style="list-style-type: none"> <li>• Clinical Quality Management</li> </ul>	(3) Evaluative Measures

Organizational Information <ul style="list-style-type: none"> <li>• Grant Administration</li> </ul>	(5) Resources/Capabilities
Budget and Budget Narrative	(6) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested.

### iii. **Budget**

See Section 4.1.iv of HRSA's [SF-424 Application Guide](#). Please note: the directions offered in the SF-424 Application Guide differ from those offered by Grants.gov. Please follow the instructions included in the Application Guide and, *if applicable*, the additional budget instructions provided below.

**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 HRSA-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, as applicable.

In addition, the RWHAP 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:

- (1) "Administrative"
- (2) "CQM"
- (3) "MAI"
- (4) "HIV Services"

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

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

Costs associated with grant administration and PC support or planning body support are all subject to the 10 percent limit on costs associated with administering the award. Recipients must determine the amounts necessary to cover all administrative and program support activities. The grant recipient 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.



The Consolidated Appropriations Act, 2016, Division H, § 202, (P.L. 114-113) 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. Note that these or other salary limitations may apply in FY 2017, as required by law.

**iv. Budget Narrative**

See Section 4.1.v. of HRSA’s [SF-424 Application Guide](#) for instructions.

**Caps on expenses:** RWHAP Part A Grant Administration Costs (including PC or planning body support) may **not** exceed 10 percent of the grant award. Administrative expenditures for subrecipients may **not** exceed 10 percent of the aggregate amount allocated for services. Recipients are allowed to allocate up to five (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 RWHAP Part A grant. By law, no more than 10 percent of the RWHAP Part A budget can be spent on administrative costs. Staff activities that are administrative in nature should be allocated to administrative costs.

If a RWHAP Part A grant recipient has contracted with an entity to provide statewide or regional RWHAP management and fiscal oversight (i.e., the entity is acting on behalf of the recipient), the cost of that contract, exclusive of subawards to providers, would count toward the recipient’s (grantee’s) 10 percent administrative cap. Providers that have contracted to provide health care services for the lead agency are considered to be subrecipients of the grantee and are subject to the aggregate 10 percent administrative cap for subrecipients.

Subrecipient administrative costs are capped at **10 percent in the aggregate**. Subrecipient administrative activities include:

- usual and recognized overhead activities, **including established indirect rates** for agencies;
- management oversight of specific programs funded under the RWHAP; and
- other types of program support such as quality assurance, quality control, and related activities (exclusive of RWHAP CQM).

As a reminder: All indirect costs charged by the subrecipient are considered an administrative cost subject to the 10 percent aggregate limit.

For further guidance on the treatment of costs under the 10 percent administrative limit, refer to PCN 15-01, *Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D* (<http://hab.hrsa.gov/affordablecareact/pcn1501.pdf>) and Frequently Asked Questions (<http://hab.hrsa.gov/manageyourgrant/faqpolicyclarificationnotice15-01.pdf>).



**CQM Costs** are those costs required to maintain a CQM program to assess the extent to which services are consistent with the current HHS guidelines for the treatment of HIV/AIDS. Examples of CQM costs include:

- CQM coordination;
- Continuous Quality Improvement (CQI) activities;
- Data collection for CQM purposes (collect, aggregate, analyze, and report on measurement data);
- Grant recipient CQM staff training/TA (including travel and registration) - this includes HRSA sponsored or HRSA approved training; and
- Training of subrecipients on CQM.

**MAI** - Refer to Section IV.ii.C.4

**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 RWHAP 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, and 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.
- Other clinical and diagnostic services regarding HIV/AIDS and periodic medical evaluations of individuals with HIV/AIDS, according to the HHS guidelines (see <http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0/>).
- Salaried or contracted personnel that provide 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 health insurance plans through the health insurance Marketplace, and benefits counseling. Services are generally provided to clients who are new to care.
- Salaried or contracted personnel that provide 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, Marketplace, 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 provide outreach to and enrollment of 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;
- 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:
  - The portion of rent for clinic pharmacy, case management, and food bank space utilized to provide core medical and support services for eligible RWHAP clients may be charged to the applicable service. Grant recipients 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 RWHAP Part A funds are used to cover all or a portion of a client's rent.

**v. 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 (required; see Section 4.1. of the HRSA's SF-424 Application Guide)*

*Attachment 2: Letters of Agreement, Memorandum of Understanding, Intergovernmental Agreements, FY 2017 Agreements and Compliance Assurances, Certifications (required)*

In addition to completing the SF-424B Assurances per instructions in the SF-424 Application Guide, also complete and submit the required RWHAP Part A Grant Program FY 2017 Agreements and Compliance Assurances (see Appendix A), which should be submitted as part of **Attachment 2**.

*Attachment 3: HIV/AIDS Demographic Table (required)*

*Attachment 4: Unmet Need Framework (required)*

*Attachment 5: Co-morbidities, Cost and Complexity Table (required)*

*Attachment 6: Letter of Assurance from Planning Council Chair/Letter of Concurrence from Planning Body (required)*

*Attachment 7: Coordination of Services and Funding Table (required)*

Provide in table format a jurisdictional HIV resources inventory, that includes: (1) public and private funding sources for HIV prevention, care, and treatment services in the jurisdiction; (2) the dollar amount and the percentage of the total available funds in fiscal year (FY) 2016 for each funding source; (3) how the resources are being used (i.e., services delivered); and (4) which component(s) of HIV prevention programming and/or steps of the HIV care continuum is/are impacted.

*Attachment 8: FY 2017 Service Category Plan Table (required)*

*Attachment 9: Core Medical Services Waiver Request (if applicable)*

*Attachment 10: FY 2017 HIV Care Continuum Work Plan (required)*

*Attachment 11: Organizational Chart (required)*

*Attachment 12: Maintenance of Effort Documentation (required)*

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 the most recently completed fiscal year prior to the application deadline.

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

*Attachments 14: Other Relevant Documents (optional)*

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. Dun and Bradstreet Data Universal Numbering System (DUNS) Number and System for Award Management**

You must obtain a valid DUNS number and provide that number in your application. You must also register with the System for Award Management (SAM) and continue to maintain active SAM registration with current information at all times during which you have an active federal award or an application or plan under consideration by an agency (unless the applicant is an individual or federal agency that is exempted from

those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the agency under 2 CFR 25.110(d)).

HRSA may not make an award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time HRSA is ready to make an award, HRSA may determine that the applicant is not qualified to receive an award and use that determination as the basis for making an award to another applicant.

If you have already completed Grants.gov registration for HRSA or another federal agency, confirm that the registration is still active and that the Authorized Organization Representative (AOR) has been approved.

The Grants.gov registration process requires information in three separate systems:

- Dun and Bradstreet (<http://fedgov.dnb.com/webform/pages/CCRSearch.jsp>)
- System for Award Management (SAM) (<https://www.sam.gov>)
- Grants.gov (<http://www.grants.gov/>)

For further details, see Section 3.1 of HRSA's [SF-424 Application Guide](#).

**Applicants that fail to allow ample time to complete registration with SAM or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.**

#### **4. Submission Dates and Times**

##### **Application Due Date**

The due date for applications under this FOA is October 18, 2016, at 11:59 P.M. Eastern Time.

See Section 8.2.5 – Summary of e-mails from Grants.gov of HRSA's [SF-424 Application Guide](#) for additional information.

#### **5. Intergovernmental Review**

The RWHAP 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.

#### **6. Funding Restrictions**

You may request funding for a project period up to one (1) year.

In addition to the general Funding Restrictions included in section 4.1.iv of the [SF-424 Application Guide](#), funds under this announcement may not be used for the following purposes:

- Cash payment to intended recipients of RWHAP services;
- Construction. 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;
- International travel;
- PrEP medications and medical services or Post-Exposure Prophylaxis (PEP), as the person using PrEP or PEP is not HIV infected, and therefore is not eligible for RWHAP 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).

Please see [Policy Clarification Notice 15-01](#) and Frequently Asked Questions for information regarding the statutory 10 percent limitation on administrative costs.

Other non-allowable costs can be found in [45 CFR 75 – Subpart E Cost Principles](#).

The General Provisions in Division H of the Consolidated Appropriations Act, 2016 (P.L. 114-113) 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 2017, as required by law.

You are required to have the necessary policies, procedures and financial controls in place to ensure that your organization complies with the all federal funding requirements and prohibitions such as lobbying, gun control, abortion, etc. The effectiveness of these policies, procedures and controls is subject to audit.

All program income generated as a result of awarded funds must be used for approved project-related activities. Program income must be used for the purposes for which the award was made, and may only be used for allowable costs under the award. For RWHAP Part A, allowable costs are limited to core medical services, support services, CQM and administrative expenses [Section 2604(a)(2)]. Program income may be utilized for elements of the program that are otherwise limited by statutory provisions, such as administrative and CQM activities that might exceed statutory caps, or unique services that are needed to maintain a comprehensive program approach but that would still be considered allowable under the award. (See PCN 15-03, [Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income](#), <http://hab.hrsa.gov/manageyourgrant/policiesletters.html>)

## 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 you in understanding the

standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist you 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 RWHAP Part A Program has six (6) review criteria:

*Criterion 1: NEED (66 points) – Corresponds to Section IV. ii. Project Narrative: Introduction, Needs Assessment/Epidemiologic Overview, HIV care continuum, Demonstrated Need, and associated attachments. Note: This section includes EIHA which is 33 points, per legislation.*

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

**A. Epidemiologic Overview (4 points)**

- 1) The Epidemiologic Overview provides a clear and comprehensive description of the burden of HIV in the jurisdiction.
- 2) HIV/AIDS Demographic Table(s) (**Attachment 3**) uses most recent data available and clearly cites sources of data.

**B. HIV Care Continuum for FY 2017 (6 points)**

Evidence of a thorough understanding of the HIV epidemic for the jurisdiction through the HIV care continuum graph, and the accuracy of the data provided for the jurisdiction as evidenced by the data sources and cites provided.

- 1) As evidenced by the narrative description of HIV care continuum:
  - a) The strength of the utilization of the HIV care continuum in planning, prioritizing, targeting, and monitoring available resources in response to the needs of PLWH.
  - b) The strength of systematic approaches developed to address each of the gaps along the HIV care continuum, including targeted interventions at each stage.
  - c) The strength of evaluation activities to gauge the impact of HIV care continuum efforts.
  - d) The strength of dissemination methods to ensure information related to planning and evaluation of the HIV care continuum is shared throughout the jurisdiction.

**C. Demonstrated Need (56 points)**

**1) Early Identification of Individuals with HIV/AIDS (EIIHA 33pts)**

***FY17 EIIHA Plan (33 pts)***

- a) The strength and feasibility of the EMA/TGA's EIIHA Plan for FY 2017 as evidenced by:
  - (1) A clear description of the process or plan for linking people identified in the EIIHA data to both prevention (for HIV negative clients) and care services (for HIV positive clients); including a description of community partners and other resources utilized to provide these services and any major collaboration with other programs and agencies including HIV prevention and surveillance programs.
  - (2) The updated estimate of individuals who are HIV positive and who are unaware of their status, and the strength of the estimate methodology;
  - (3) Inclusion of all populations for the EIIHA Plan;
  - (4) The primary activities that will be undertaken, including system level interventions (e.g., routine testing in clinical settings, expanding partner services);
  - (5) Major collaborations with other programs and agencies, including HIV prevention and surveillance programs; and
  - (6) Planned outcomes of the overall EIIHA strategy.
- b) The extent to which the proposed FY 2017 EIIHA Plan contributes to the goals of the NHAS 2020.
- c) The extent to which the proposed FY 2017 EIIHA Plan contributes to the goals of the HIV care continuum.
- d) The extent to which the EIIHA planned activities addresses the Unmet Need estimate population.
- e) Evidence that the EIIHA Plan for FY 2016 (e.g., process, activities and outcomes) influenced the development of the EIIHA Plan for FY 2017.
- f) If applicable, the strength and feasibility of planned efforts to remove legal barriers, including State laws and regulations, to routine HIV testing.
- g) The appropriateness of the three (3) distinct target populations selected for the FY 2017 EIIHA Plan as evidenced by:
  - (1) Why the target population was chosen and how the epidemiological data, Unmet Need estimate data, or other data supports that decision;
  - (2) Specific challenges with or opportunities for working with the targeted population;
  - (3) Specific activities that will be utilized with the target population;

- (4) 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);
  - (5) The responsible parties, including any coordination with other agencies and/or programs for ensuring each of the activities are implemented, and their respective roles;
  - (6) Planned outcomes that will be achieved for the target population as a result of implementing the EIIHA Plan activities.
- h) The strength of EIIHA data utilization in planning for services in the jurisdiction.
  - i) The strength of evaluation activities to gauge the impact of efforts on the EIIHA population.
  - j) The strength of dissemination methods to ensure information related to planning and evaluation of EIIHA data is shared throughout the jurisdiction.

## **2) Unmet Need (8 points)**

- a) The clarity and completeness of the Unmet Need framework estimates (**Attachment 4**) supported by appropriate data sources and calculations.
- b) A clear explanation of how the estimate derived from the HIV care continuum in 2016 (last year) compares to the estimate for FY 17.
- c) A clear explanation of how the definition of Retained in Care used to calculate unmet need differs from the HIV care continuum definition and the challenges in using the definition in the FOA.
- d) A clear explanation of the data capabilities in the jurisdiction and the data limitations in calculating unmet need.
- e) A clear explanation of the challenges in using the retention in care measure to calculate unmet need and any suggested adjustments to better reflect the true estimate in the jurisdiction.
- f) A clear explanation of the following: how the estimate derived from the HIV care continuum impacts the approach to the unmet need estimate; whether it requires revision or modification for identifying unmet need populations; characteristics of populations identified; strategies to link those populations back into care; and elimination of barriers to improve access to care.
- g) A clear explanation of the data used to determine unmet need using HIV care continuum data.

## **3) Service Gaps (3 points)**

- a) The extent to which the applicant demonstrates an understanding of the



service gaps within the jurisdiction and the strength of the method used to prioritize and address these service gaps with RWHAP Part A funding.

**4) Minority AIDS Initiative (6 points)**

- a) The extent to which the applicant clearly identified minority populations based on data presented in the epidemiologic overview and specific sub-groups targeted with MAI funds and an illustration of any significant health disparities presented in a care continuum table.
- b) A clear description of: the planning process used in determining the needs of identified MAI populations; the specific culturally appropriate, population-tailored interventions and community partnerships; and the impact of the specific interventions and the evaluation and dissemination methods to stakeholders.

**5) Special Populations and Complexity of Providing Care (6 points)**

- a) The extent to which the applicant demonstrates a thorough understanding of the disproportionate impact on emerging (if applicable) and under-represented populations.
- b) The strength of the impact of co-morbidities and co-factors on the cost and complexity of care in the EMA/TGA (narrative and **Attachment 5**).

*Criterion 2: RESPONSE (14 points) – Corresponds to Section IV. ii. Project Narrative: Methodology/Planning and Resource Allocation, Work Plan/Funding for Core and Support Services, 2016 HIV Care Continuum Work 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 described in the application are capable of addressing the problem and attaining the project objectives.

**A. Planning and Resource Allocation (6 points)**

**1) Strength of the Community Input Process (3 points)**

- a) The strength of the planning process in the EMA or TGA that is evidenced by community input, priority setting, and allocation processes.
- b) Evidence that the prioritization and allocation process addresses the data and information presented in the Need section of the application.
- c) The appropriateness 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.
- d) The extent to which PLWH were involved and evidence that their

priorities were considered in the planning and allocation process.

- e) The extent to which MAI funding was considered during the planning process.
- f) The extent to which anticipated changes due to the changing health care landscape were considered in developing priorities.

**2) The Letter of Assurance or Concurrence signed by the PC chair(s) or planning body leadership fully addressed, and provided evidence of the following components (Attachment 6) (1 point):**

- a) The FY 2016 formula, supplemental, and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the PC;
- b) That all FY 2016 Conditions of Award relative to the PC have been addressed;
- c) The FY 2016 priorities were determined by the PC, and the approved process for establishing those priorities was used by the PC;
- d) Date of membership training; and
- e) 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.

**3) Coordination of Services and Funding Streams (2 points)**

- a) The clarity and completeness of the table "Coordination of Services and Funding Streams" (**Attachment 7**) in describing the availability of other public funding in the EMA/TGA, including both the dollar amount(s) and the percentage of the total available funds in 2016 to include the following:
  - (1) other RWHAP funding (Parts B, C, D, and F);
  - (2) federal/state and local sources of public funding; and
  - (3) HIV/AIDS-related service funds available in FY 2016.
- b) The clarity and comprehensiveness of the description of how the different funding sources interact to ensure continuity of HIV prevention, care, and treatment services in the jurisdiction.
- c) Based on the data in **Attachment 7**, the clarity and strength of the description and justification identifying any needed resources and/or services in the jurisdiction and steps taken to secure them.

**B. Funding for Core and Support Services (6 points)**

**1) FY 2017 Service Category Plan (Attachment 8) (4 points)**

- a) The clarity and completeness of the table that illustrates how RWHAP Part A and MAI core medical and support services are funded in the EMA/TGA as evidenced by the inclusion of complete data on service categories, priority number, funding amount, unduplicated clients, service unit definition, service units, and target populations (for MAI services only) for FYs 2015, 2016, and 2017.
- b) The comprehensiveness and strength of the FY 2017 Service Category Plan. The extent to which the narrative expands and clarifies the information presented in the Plan and addresses the following:
  - (1) Prioritized core medical services that will not be funded with FY 2017 RWHAP funds and how these services will be delivered in the EMA/TGA; (e.g., services funded by Medicaid, Medicaid expansion, health insurance marketplaces, CHIP, 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, and comprehensiveness of services;
  - (3) How planned activities assure that services delivered by providers are culturally and linguistically appropriate to the populations served within the EMA/TGA;
  - (4) Factors that contributed to changes in funding within the service categories (e.g., Medicaid expansion, changing health care landscape, increase/decrease in RWHAP Part A award, etc.);
  - (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 changes to service categories are linked to needs assessments or updates (including Unmet Need or new initiatives).

**2) 2017 HIV Care Continuum Work Plan (2 points)**

- a) The strength and completeness of the HIV Care Continuum Work Plan depicting how RWHAP services will be used to improve indicators along the HIV care continuum (**Attachment 10**).

**C. Resolution of Challenges (2 points)**

The strength and feasibility of approaches to resolve challenges and barriers identified throughout the application (e.g., changing health care landscape, community engagement, etc.), as well as challenges encountered in integrating the HIV care continuum into planning and implementing the RWHAP Part A program.

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

**A. Clinical Quality Management (CQM) (5 points)**

- 1) Infrastructure: The strength of the CQM Program staff, FTEs, roles, responsibilities, contracted staff and activities undertaken by contractor, and coordination of activities with other RWHAP recipients in jurisdiction.
- 2) Performance measurement: The strength of performance measurement as evidenced by performance measures for each service category for which the applicant funds; 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 sub-recipients; and summarized performance measure data including trends for outpatient/ambulatory medical care and medical case management; and how performance measure data are analyzed to evaluate for disparities in care, and actions taken to eliminate disparities;
- 3) Quality Improvement: The strength of the processes for identifying priorities for quality improvement, as evidenced by examples of specific quality improvement projects undertaken for outpatient/ambulatory medical care and medical case management, and the process used to monitor and support subrecipient engagement in quality improvement projects; and efforts aimed at improving HIV viral suppression within the jurisdiction.

*Criterion 4: IMPACT (5 points) – Corresponds to Section IV. ii. Project Narrative: Methodology/Impact of Funding and associated attachments.*

**A. Impact of Funding (5 points)**

- 1) Impact and Response to Reduction in RWHAP PART A Formula Funding (2 points)**
  - a) The extent to which the applicant demonstrated a thorough understanding of both the impact and response to funding reduction (if applicable).
- 2) Impact of the Changing Health Care Landscape(3 points)**
  - a) The clarity and completeness of the table with available data on current PLWH who are uninsured and living in poverty in their jurisdiction.
  - b) The extent to which the applicant demonstrated a thorough understanding of the impact of insurance expansion, outreach and enrollment, Marketplace options, and successes and outcomes during the most recent enrollment period.

*Criterion 5: RESOURCES/CAPABILITIES (5 points) – Corresponds to Section IV. ii. Project Narrative: Organizational Information/Grant Administration and associated attachments.*

The extent to which project personnel are qualified by training and/or experience to implement and carry out the project. The capabilities of the applicant organization and the quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project. For competing continuations, past performance will also be considered.

## **A. Grant Administration (5 points)**

### **1) Program Organization (2 points)**

- a) The capacity of the local agency responsible for the grant and the entity responsible for administering the RWHAP Part A Programs evidenced by the department, unit, staffing levels (FTEs, including any vacancies), fiscal and/or management agents, planning and evaluation bodies, and in-kind support staff (**Attachment 11** - Organization Chart);
- b) The strength and viability of the process and mechanisms, including data collection, used to ensure providers funded through multiple RWHAP 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. Recipient and Subrecipient Accountability (3 points)**

### **1) Program Oversight**

- a) The strength and feasibility of the steps taken by the EMA/TGA in 2016 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) The strength and appropriateness of corrective actions planned or taken to address programmatic findings in FY 2016, as well as the appropriateness of the number of subrecipients that received TA in FY 2016, to date (given the types, scope, and timeline of TA).

### **2) Fiscal Oversight**

- a) The strength and effectiveness of the process used by program and fiscal staff to coordinate activities ensuring adequate reporting, reconciliation, and tracking of program expenditures.
- b) The strength of the process used to separately track formula, supplemental, MAI, and carry over funds, including data systems utilized, and the process used to ensure timely monitoring and redistribution of funds.
- c) The strength of the coordinated process for reviewing subrecipient compliance with the single audit requirement in Subpart F – Audit Requirements of 45 CFR 75; and, if there were RWHAP findings in any subrecipients' single audit reports, the strength of the process to ensure that subrecipients have taken appropriate corrective action.
- d) The strength of the process for reimbursing subrecipients, from the time a voucher/invoice is received to a payment being made.

*Criterion 6: SUPPORT REQUESTED (5 points) – Corresponds to Section IV. ii. Project Narrative: Organizational Information, MOE, Budget and associated attachments.*

- A. The reasonableness and completeness of the SF-424A for each year of the project period in relation to the objectives.
- B. 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.
- C. 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.

## **2. Review and Selection Process**

The objective review provides advice to the individuals responsible for making award decisions. The highest ranked applications receive priority consideration for award within available funding. In addition to the ranking based on merit criteria, HRSA approving officials also may apply other factors in award selection, (e.g., geographical distribution), if specified below in this FOA. HRSA may also consider assessment of risk and the other pre-award activities described in Section 3 below.

Please see Section 5.3 of HRSA's [SF-424 Application Guide](#) for more details.

This program does not have any funding priorities, preferences or special considerations.

## **3. Assessment of Risk and other Pre-award Activities**

HRSA may elect not to fund applicants with management or financial instability that directly relates to the organization's ability to implement statutory, regulatory or other requirements ([45 CFR § 75.205](#)).

Applications receiving a favorable objective review that HRSA is considering for funding are reviewed for other considerations. These include, as applicable, cost analysis of the project/program budget, assessment of the applicant's management systems, ensuring continued applicant eligibility, and compliance with any public policy requirements, including those requiring just-in-time submissions. You may be asked to submit additional programmatic or grants information (such as an updated budget or "other support" information) or to undertake certain activities (such as negotiation of an indirect cost rate) in anticipation of an award. However, even at this point in the process, such requests do not guarantee that an award will be made. Following review of all applicable information, the HRSA approving and business management officials will determine whether an award can be made, if special conditions are required, and what level of funding is appropriate.

Award decisions are discretionary and are not subject to appeal to any HRSA or HHS official or board.

Effective January 1, 2016, HRSA is required to review and consider any information about the applicant that is in the [Federal Awardee Performance and Integrity Information System \(FAPIIS\)](#). An applicant may review and comment on any information about itself that a federal awarding agency previously entered. HRSA will consider any comments by the applicant, in addition to other information in [FAPIIS](#) in making a judgment about the applicant's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed by applicants as described in 45 CFR [§ 75.205 Federal Awarding Agency Review of Risk Posed by Applicants](#).

A determination that an applicant is not qualified will be reported by HRSA to FAPIIS (45 CFR [§ 75.212](#)).

#### **4. Anticipated Announcement and Award Dates**

HRSA anticipates issuing/announcing awards prior to the start date of March 1, 2017.

## **VI. Award Administration Information**

### **1. Award Notices**

HRSA will issue the Notice of Award prior to the start date of March 1, 2017. 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](#).

### **3. Reporting**

The successful applicant under this FOA must comply with Section 6 of HRSA's [SF-424 Application Guide](#) and the following reporting and review activities:

- 1) **Progress Report(s).** The recipient 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 RWHAP Part A and MAI expenditures; further information will be provided in the notice of award.
- 5) **Ryan White Services Report.** The awardee must comply with data requirements of the RSR and mandate compliance by each of its subrecipients. The RSR captures information necessary to demonstrate program performance and accountability. Please refer to the RSR website at <http://hab.hrsa.gov/manageyourgrant/clientleveldata.html> for additional information.
- 6) **Waiver to Request Carryover.** The RWHAP legislation requires a waiver to request carryover of unobligated formula funds before the end of the period of performance. A carryover waiver application, together with the estimated 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).
- 7) **Integrity and Performance Reporting.** The Notice of Award will contain a provision for integrity and performance reporting in [FAPIS](#), as required in [45 CFR part 75 Appendix XII](#).

## VII. Agency Contacts

You may obtain additional information regarding business, administrative, or fiscal issues related to this FOA by contacting:

Karen Mayo  
Grants Management Specialist  
Division of Grants Management Operations, OFAM  
Health Resources and Services Administration  
5600 Fishers Lane, Room 10NWH04  
Rockville, MD 20857  
Telephone: (301) 443-3555  
Fax: (301) 594-4073  
E-mail: [KMayo@hrsa.gov](mailto: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: HIV/AIDS Bureau  
Health Resources and Services Administration  
5600 Fishers Lane, Room 09W12  
Rockville, MD 20857  
Telephone: (301) 443-9091  
Fax: (301) 443-5271  
E-mail: [Syoung@hrsa.gov](mailto:Syoung@hrsa.gov)



You may need assistance when working online to submit your application forms electronically. 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](mailto:support@grants.gov)

Self-Service Knowledge Base: <https://grants-portal.psc.gov/Welcome.aspx?pt=Grants>

Successful applicants/recipients 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 Contact Center, Monday-Friday, 8:00 a.m. to 8:00 p.m. ET:

HRSA Contact Center

Telephone: (877) 464-4772

TTY: (877) 897-9910

Web: <http://www.hrsa.gov/about/contact/ehbhelp.aspx>

## VIII. Other Information

### Technical Assistance:

You are encouraged to participate in a TA webinar for this funding opportunity. The technical assistance webinar is scheduled for September 13, 2016 from 2:00 – 4:00 P.M. 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 information for the webinar includes:

**Dial-in Phone Number: 1-800-619-7490**

**Passcode: 5798880#**

**To access the webinar online, go to the Adobe Connect URL:**

**[https://hrsa.connectsolutions.com/dmhaf\\_fy17\\_foa\\_ta/](https://hrsa.connectsolutions.com/dmhaf_fy17_foa_ta/)**

## IX. Tips for Writing a Strong Application

See Section 4.7 of HRSA's [SF-424 Application Guide](#).

## Appendix A

### FY 2017 AGREEMENTS AND COMPLIANCE ASSURANCES Ryan White HIV/AIDS Program *Part A* *HIV Emergency Relief Grant Program*

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

**Pursuant to Section 2602(a)(2)** <sup>1, 2</sup>

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/Planning Body.

**Pursuant to Section 2604(a)**

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<sup>1</sup> All statutory references are to the Public Health Service Act, unless otherwise specified.

<sup>2</sup> TGAs are exempted from the requirement related to Planning Councils, but must provide a process for obtaining community input as described in **Section 2609(d)(1)(A)**. TGAs that have currently operating Planning Councils are strongly encouraged to maintain that structure.

The EMA/TGA will expend funds according to priorities established by the Planning Council/Planning Body, and for core medical services, support services, and administrative expenses only.

**Pursuant to 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 (including Planning Council or planning body expenses), and in accordance with the legislative definition of administrative activities, and the allocation of funds to subrecipients 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 five 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 period of performance, 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 health care 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date