

**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-16-021

Catalog of Federal Domestic Assistance (CFDA) No. 93.914

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2016

Application Due Date: November 2, 2015

*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.*

Release Date: August 27, 2015

Issuance Date: August 27, 2015

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

Authority: Public Health Service Act, Sections 2601-2610, and 2693(b)(2)(A) (42 USC 300ff-11 – 300ff-20, and 300ff-121(b)(2)(A)), 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) 2016 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-16-021
Due Date for Applications:	November 2, 2015
Anticipated Total Annual Available Funding:	\$620,079,915
Estimated Number and Type of Award(s):	Up to 53 grants
Estimated Award Amount:	Varies
Cost Sharing/Match Required:	No
Project Period:	March 1, 2016 through February 28, 2017 (one (1) year)
Eligible Applicants:	<p>Part A recipients that are classified as an EMA or as a TGA and continue to meet the statutory requirements are eligible to apply for these funds.</p> <p>[See Section III-1 of this funding opportunity announcement (FOA) for complete eligibility information.]</p>

Application Guide

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

Technical Assistance

Information for the September 24, 2015, 2:00-4:00 EST Webinar on the Part A 2016 Application TA National Call is:

Adobe Connect URL Website:

https://hrsa.connectsolutions.com/pre-app_ta_2016/

Dial-in audio line:

1-877-779-7419

Passcode: 7898318#

Table of Contents

I. PROGRAM FUNDING OPPORTUNITY DESCRIPTION	1
1. PURPOSE.....	1
2. BACKGROUND	3
II. AWARD INFORMATION	4
1. TYPE OF APPLICATION AND AWARD	4
2. SUMMARY OF FUNDING	5
III. ELIGIBILITY INFORMATION.....	5
1. ELIGIBLE APPLICANTS	5
2. COST SHARING/MATCHING	6
3. OTHER	6
IV. APPLICATION AND SUBMISSION INFORMATION.....	6
1. ADDRESS TO REQUEST APPLICATION PACKAGE.....	6
2. CONTENT AND FORM OF APPLICATION SUBMISSION.....	6
i. <i>Project Abstract</i>	7
ii. <i>Project Narrative</i>	7
iii. <i>Budget</i>	31
iv. <i>Budget Justification Narrative</i>	32
v. <i>Attachments</i>	35
3. DUN AND BRADSTREET UNIVERSAL NUMBERING SYSTEM NUMBER AND SYSTEM FOR AWARD MANAGEMENT.....	36
4. SUBMISSION DATES AND TIMES.....	37
5. INTERGOVERNMENTAL REVIEW	37
6. FUNDING RESTRICTIONS	37
V. APPLICATION REVIEW INFORMATION	38
1. REVIEW CRITERIA.....	38
2. REVIEW AND SELECTION PROCESS	46
3. ANTICIPATED ANNOUNCEMENT AND AWARD DATES	46
VI. AWARD ADMINISTRATION INFORMATION.....	46
1. AWARD NOTICES	46
2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS.....	46
3. REPORTING	46
VII. AGENCY CONTACTS	47
VIII. OTHER INFORMATION.....	48
IX. TIPS FOR WRITING A STRONG APPLICATION.....	49

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. Part A funds provide direct financial assistance to an eligible metropolitan area (EMA) or a transitional grant area (TGA) that has been severely affected by the HIV epidemic. Grants assist eligible program areas in developing or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV through the provision of formula, supplemental, and Minority AIDS Initiative (MAI) funds. 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 meet the criteria of enabling individuals and families living with HIV/AIDS to access and remain in primary medical care to improve their medical outcomes.

HRSA/HAB recognizes that Part A EMAs and TGAs must use grant funds to support and further develop and/or expand systems of care to meet the needs of PLWH within the EMA/TGA and strengthen strategies to reach minority populations. HAB 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 HRSA's Bureau of Primary Health Care, Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and the U.S. Department of Housing 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 United States (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:

- In accordance with the RWHAP legislation (Sec. 2603 (a)(4)) of the PHS Act hold harmless will not be a factor in the FY 2016 RWHAP Part A awards.
- Information on Ryan White and the Affordable Care Act, along with Policy Clarification Notices can be found at <http://hab.hrsa.gov/affordablecareact/>.

- Greater emphasis has been placed on the HIV Care Continuum. Applicants are expected to include a graph illustrating the HIV Care Continuum in the EMA/TGA and an explanation of how the HIV Care Continuum is utilized in your jurisdiction. Refer to the Needs Assessment Section IV.2.ii for requirements.
- The Unmet Need requirements in this funding announcement have been updated and included in Section IV.2.ii. Needs Assessment 3) b. Unmet Need. Please review carefully when preparing this section of your application.

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

- As an applicant and current recipient, you are required to have implemented the Part A National Monitoring Standards at the grant recipient and provider/subrecipient levels. HRSA has developed and distributed guidelines outlining the responsibilities of HRSA, the grant recipient, and provider/subrecipient staff. The National Monitoring Standards can be found at: <http://hab.hrsa.gov/manageyourgrant/granteebasics.html>.
- Women, Infants, Children and Youth (WICY) waiver requests are no longer part of the application process. The WICY waiver reporting format was revised to allow recipients to submit a waiver request and provide supporting data with the annual progress report.
- Part A funds are subject to Section 2604(c) of the PHS Act which requires that not less than 75 percent of the funds remaining after reserving funds for administration and clinical quality management be used to provide core medical services that are needed in the EMA/TGA for individuals with HIV/AIDS who are identified and eligible under the RWHAP. Core medical services are listed in section 2604(c)(3) of the PHS Act, and support services allowed under Part A are limited to services that are needed for individuals with HIV/AIDS to achieve their medical outcomes, as defined by the RWHAP. The most recent service definitions can be found in the latest version of the National Monitoring Standards, located at <http://hab.hrsa.gov/manageyourgrant/granteebasics.html>. The burden is on the applicant to accurately propose plans and projections using the most recent versions of the Standards and definitions that are posted when an application is submitted.
- 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 2016. 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 2016 Part A waiver request must include funds awarded under the Minority AIDS Initiative (MAI). A waiver request that does not include MAI will not be considered. If submitting with the application, a core medical services waiver request should be included as **Attachment 9**.

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

2. Background

This program is authorized by the PHS Act, Sections 2601-2610 and 2693(b)(2)(A), (42 USC 300ff-11– 300ff-20 and 300ff-121(b)(2)(A)), 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 grants to EMAs and TGAs include formula and supplemental components, as well as MAI funds which support services targeting minority populations. Formula grants are based on living HIV/AIDS cases, as of December 31, in the most recent calendar year for which data are available, as reported to and confirmed by the CDC. Therefore, applicants are required to report on the number of persons living with HIV and AIDS in their jurisdictions. Supplemental grants are awarded competitively on the basis of demonstrated need and other criteria. MAI funding is awarded using a formula that is based on the distribution of living HIV/AIDS cases among racial and ethnic minorities. In each EMA, local planning councils (PC) set priorities and allocate Part A funds on the basis of the size, demographics, and needs of the population living with or affected by HIV. TGAs are required to use a community planning process. While the use of PCs is optional pending further direction from statutory provisions, and/or appropriations language, TGAs that have currently operating PCs are strongly encouraged to maintain that structure. Applicants are reminded that MAI funds should be fully integrated into Part A planning, priority setting and allocation processes. The legislation can be obtained at: <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title42/html/USCODE-2011-title42-chap6A-subchapXXIV.htm>.

Affordable Care Act

As part of the Affordable Care Act, the health care law enacted in 2010, several significant changes have been made in the health insurance market that expand options for health care coverage, including those options for people living with HIV/AIDS. The Affordable Care Act creates new state-based health care coverage marketplaces, also known as exchanges, and a federally-facilitated health care coverage marketplace to offer millions of Americans access to affordable health insurance coverage. Under the Affordable Care Act individuals with incomes between 100 to 400 percent of the Federal Poverty Level (FPL) may be eligible to receive advance payments of premium tax credits and/or cost-sharing reductions to help pay for the cost of enrolling in qualified health insurance plans and for coverage of essential health benefits. In states that choose to expand Medicaid, non-disabled adults with incomes of up to 133 percent of FPL become eligible for the program, providing new coverage options for many individuals who were previously ineligible for Medicaid. In addition, the law requires health plans to cover certain recommended preventative services without cost-sharing, making health care more affordable and accessible for Americans. These health care coverage options may be reviewed at <http://hab.hrsa.gov/affordablecareact/keyprovisions.pdf>.

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

from the new health care coverage opportunities. For information on allowable outreach and enrollment activities, visit <http://www.hab.hrsa.gov/affordablecareact/outreachenrollment.html>. Recipients and subrecipients should also assure that individual clients are enrolled in any appropriate health care coverage whenever possible or applicable, and informed about the financial or coverage consequences if they choose not to enroll. For more information on the marketplaces and the health care law, visit <http://www.healthcare.gov>.

HIV Care Continuum

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

The difficult challenge of executing these lifesaving steps is demonstrated by the data from the CDC, which estimate that only 30 percent of individuals living with HIV in the United States have complete HIV viral suppression. Data from the 2013 Ryan White Service Report (RSR) indicate that there are better outcomes in Ryan White HIV/AIDS Program (RWHAP) funded agencies with approximately 79 percent of individuals who received RHWAP-funded HIV primary care being virally suppressed. Such findings underscore the importance of supporting effective interventions for linking HIV-positive individuals into care, retaining them in care, and helping them adhere to their combination antiretroviral regimens.

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

The HIV Care Continuum measures also align with the [HHS Common HIV Core Indicators](#) approved by the Secretary and announced in August 2012. The HHS Common HIV Core Indicators were developed in coordination with other Department of Health and Human Services agencies. RWHAP recipients and providers are required to submit data through the Ryan White Services Report (RSR). Through the RSR submission, HAB currently collects the data elements to produce the HHS Common HIV Core Indicators. HAB will calculate the HHS Core Indicators for the entire RWHAP using the RSR data to report six of the seven HHS Common HIV Core Indicators to the Department of Health and Human Services, Office of the Assistant Secretary for Health.

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

This program will provide funding during federal fiscal year 2016. Approximately \$620,079,915 is expected to be available annually to fund fifty-three (53) recipients. The actual amount available will not be determined until enactment of the final FY 2016 Federal budget. This program announcement is subject to the appropriation of funds, and is a contingency action taken to ensure that, should funds become available for this purpose, applications can be processed, and funds can be awarded in a timely manner. The project period is one (1) year, March 1, 2016 – February 28, 2017.

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

Please see [Policy Clarification Notice #15 – 01](#) 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 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 Part A. For all newly eligible areas, the boundaries are based on current OMB MSA boundary definitions. The only exception is Ponce, Puerto Rico, which uses different boundaries than those that were in effect when that jurisdiction first received funding. The decision to change the boundaries for this particular TGA was the result of litigation, which is currently on appeal. HRSA has consistently maintained that the RWAHP legislation requires that geographic boundaries for EMAs and TGAs must remain fixed in time.

Therefore, Part A recipients that are classified as an EMA or as a TGA and continue to meet the statutory requirements are eligible to apply for these funds. For an EMA, this is more than 2,000 cases of AIDS reported and confirmed during the most recent five calendar years, and for a TGA, this is at least 1,000, but fewer than 2,000 cases of AIDS reported and confirmed during the most recent period of five 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 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

Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

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

Maintenance of Effort (MOE) - The RWHAP legislation, section 2605(a)(1)(B) of the PHS Act, requires 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 1-year period preceding the FY for which the grant recipient is applying to receive a Part A grant. Section 2604(b)(1) of the PHS Act states: “In general – The chief elected official of an eligible area shall use amounts from a grant under Section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services.” Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the legislation and HRSA/HAB service definitions distributed to all recipients. Part A recipients must document they have met the 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. Applicants must download the SF-424 application package associated with this FOA following the directions provided at [Grants.gov](https://www.grants.gov).

2. Content and Form of Application Submission

Section 4 of HRSA’s [SF-424 Application Guide](#) provides instructions for the budget, budget justification, staffing plan and personnel requirements, assurances, certifications, and abstract.

You must submit the information outlined in the Application Guide in addition to the program specific information below. All applicants are responsible for reading and complying with the instructions included in HRSA's [SF-424 Application Guide](#) except where instructed in the 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**. Page limit should not exceed 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 applicants 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.

Program-Specific Instructions

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

i. Project Abstract

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

- a) general demographics of EMA/TGA;
- b) demographics of HIV/AIDS populations in the EMA/TGA;
- c) geography of the EMA/TGA with regard to communities affected by HIV/AIDS and the location of HIV/AIDS services in relation to those communities, including minority populations served with Minority AIDS Initiative (MAI) funds;
- d) description of the 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;
- e) number of years the EMA/TGA has received Part A and MAI funding;
- f) changes to your Part A program as a result of ACA implementation; and
- g) 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 should briefly describe how the EMA or TGA will utilize RWHAP Part A grant funds in support of a comprehensive continuum of high-quality care and treatment for PLWH in the Part A service area.
- **NEEDS ASSESSMENT** -- *Corresponds to Section V's Review Criterion #1*
The purpose of this section is to demonstrate the severity of the HIV/AIDS epidemic in the EMA/TGA, using quantifiable data on HIV epidemiology, co-morbidities, cost of care for 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.

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

1) Jurisdictional Profile

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

- a. Use a table to describe the EMA/TGA incidence and prevalence of HIV and AIDS for the past three calendar years (2012, 2013, and 2014). Clearly cite the data sources.
- b. Use a table to provide HIV/AIDS cases by demographic characteristics (age, ethnicity, race, and gender) and exposure category in the EMA/TGA for the past three calendar years (2012, 2013, and 2014); if data for this three year period is unavailable, use data from the most current three year period and provide an explanation. Submit as **Attachment 3**.

2) HIV Care Continuum for FY 2016

The HIV Care Continuum allows recipients and planning bodies to measure progress and to direct HIV resources most effectively. By examining the proportion of PLWH engaged in each stage of the HIV Care Continuum, HIV planners are able to pinpoint where gaps may exist in connecting PLWH to sustained, quality care, and to implement system improvements and service enhancements that better support individuals as they move from one stage in the continuum to the next. Knowing where the drop-offs are most pronounced, and for what populations, is vital to knowing how, where, and when to intervene to deliver targeted services. The Executive Order on the HIV Care Continuum Initiative that was released on July 15, 2013, is available at <http://www.whitehouse.gov/the-press-office/2013/07/15/executive-order-hiv-care-continuum-initiative>.

- a. Provide a graph which depicts the RWHAP Part A HIV Care Continuum in the EMA/TGA. The graph must include data for calendar year 2014 or the most recent calendar year for each stage of the HIV Care Continuum. At a minimum, programs should use their available RSR data to populate the continuum for RWHAP-eligible individuals. If programs have access to a greater pool of health service utilization or population data, it is strongly encouraged that it be used in the continuum graph. Applicants must clearly explain their data set and what data sources are being utilized. To populate the beginning of the continuum, the Diagnosed and Linkage to Care stages, applicants should at a minimum use their Early Identification of Individuals with HIV/AIDS (EIIHA) data. These data may be obtained from local or state prevention programs. Another tool for using data is the CDC's *Data to Care: A Public Health Strategy Using HIV Surveillance Data to Support the HIV Care Continuum*. *Data to Care* is a toolkit designed to share information and resources to assist health departments in developing and implementing a *Data to Care* program. The toolkit can be accessed at <http://www.effectiveinterventions.org/en/HighImpactPrevention/PublicHealthStrategies/DatatoCare.aspx>.

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

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

- i. **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. This 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 have been reported as having died.
- ii. **Linkage to Care:** The number of people diagnosed with HIV in a given calendar year that had one or more documented medical visits, viral load or CD4 tests within three 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.
- iii. **Retained in Care:** The number of diagnosed individuals who had two or more documented medical visits, viral load tests, or CD4 tests, performed at least three months apart in the measurement year.
- iv. **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).
- v. **Viral Load Suppression:** The number of individuals whose most recent HIV viral load within the measurement year was less than 200 copies/mL.

- b. The HIV Care Continuum described above should illustrate the HIV epidemic for the EMA/TGA. Utilizing the data from the graph, create a narrative which discusses the following:
 - i. How the HIV Care Continuum is currently utilized in planning, prioritizing, targeting and monitoring available resources in response to needs of PLWH in the jurisdiction and in improving engagement at each stage of the continuum.
 - ii. Describe any systematic approaches developed to address each of the gaps along the HIV Care Continuum, including targeted interventions aimed at each stage (i.e., Linkage to Care, Retention in Care, Viral Load Suppression, etc.).
 - iii. Any significant health disparities identified related to race, gender, sexual orientation and age among populations within your jurisdiction's HIV Care Continuum and current activities targeted or planned to address these disparities.
 - iv. Any barriers or unique challenges (i.e., data collection/ sharing, collaboration with other local, state and federal programs, etc.) that exist in developing and utilizing the HIV Care Continuum model in the Part A program. Describe how the Part A program addresses these barriers or unique challenges.

3) 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 2016 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, Minority AIDS Initiative (MAI), Special Populations, and Local Pharmaceutical Assistance Programs (LPAP).

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

The purpose of this section is to describe the strategy, plan, and data associated with ensuring that individuals who are unaware of their HIV status are identified, informed of their status, referred to supportive services, and linked to medical care if HIV positive. The goals of this initiative are to: 1) increase the number of individuals who are aware of their HIV status, 2) increase the number of HIV positive individuals who are in medical care, and 3) increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative.

Use of RWHAP funds for HIV testing:

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

- i. HIV testing and targeted counseling;

- ii. Referral services;
- iii. Linkage to care; and
- iv. Health education and literacy training that enable clients to navigate the HIV system of care.

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

(1) EIIHA Data

Select **three** (3) target populations in the previously submitted FY 2015 EIIHA Plan. For the selected three target populations, provide the following data for January 1, 2015 – June 30, 2015:

Newly diagnosed positive HIV test events:

(a) Number of test events

- *HIV testing event*

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

(b) Number of newly diagnosed positive test events

- *Newly identified HIV-positive result*

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

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

- *Linkage to HIV medical care*

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

- *HIV medical care*

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

(d) Number of newly diagnosed confirmed positive test events

- *Newly identified confirmed HIV-positive result*

A confirmed HIV-positive test result associated with a client who does not self-report having previously tested HIV positive and who has not

been reported to jurisdiction's surveillance department as being HIV positive.

- *Confirmed HIV-positive result*

A testing event with a positive test result per the CDC HIV testing algorithm.

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

- *Referral to partner services*

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

- *Interviewed for partner services*

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

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

- *Referral to prevention services*

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

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

- *CD4/VL*

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

Previously diagnosed positive HIV test events:

(a) Number of test events

- *HIV testing event*

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

(b) Number of previously diagnosed positive test events

- *Previously identified HIV-positive result*

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

- (c) Number of previously diagnosed positive test events with client re-engaged in HIV medical care
- *Linkage to HIV medical care*
This calculated indicator determines whether a client was linked to HIV medical care within 90 days of the re-diagnosis. In order for a client to be linked to care, the client must both be referred to HIV medical care and attend the first medical care appointment.
 - *HIV medical care*
HIV medical care includes medical services for HIV infection including evaluation of immune system function and screening, treatment and prevention of opportunistic infections.
- (d) Number of previously diagnosed confirmed positive test events
- *HIV testing event*
An HIV testing event is a sequence of one or more HIV tests conducted with the client to determine his or her HIV status. During a single testing event, a client may be tested once (e.g., one rapid test or one conventional test) or multiple times (e.g., one rapid test followed by one confirmatory test to confirm a preliminary HIV-positive test result as per the established CDC HIV testing algorithm).
 - *Confirmed HIV-positive result*
A testing event with a positive test result for a confirmatory HIV test as per the [CDC testing algorithm](#).
- (e) Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services
- *Referral to partner services*
This calculated indicator determines whether a client with a confirmed HIV-positive test result was given a referral to partner services.
 - *Interviewed for partner services*
This calculated indicator determines whether a client with a confirmed HIV-positive test result was interviewed for Partner Services within 30 days of receiving their confirmed positive test result. In order for a client to be counted as interviewed for Partner Services, the client must both be referred to Partner Services and interviewed within 30 days of positive test result.
- (f) Number of previously diagnosed confirmed positive test events with client referred to prevention services
- *Referral to prevention services*
This indicator determines whether a client with confirmed HIV-positive test results was given a referral to HIV prevention services.
- (g) Number of previously diagnosed confirmed positive test events linked to and accessed CD4 cell count and viral load testing

- *CD4/VL*

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

(2) FY 2016 EIIHA Plan

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

(a) Describe the planned activities of the EMA/TGA EIIHA Plan for FY 2016.

Include the following information:

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

(b) Describe how the proposed FY 2016 EIIHA Plan contributes to the goals of the National HIV/AIDS Strategy.

(c) Describe how the proposed FY 2016 EIIHA Plan contributes to the goals of the White House Continuum of Care Initiative. The Executive Order on the HIV Care Continuum Initiative that was released on July 15, 2013, is available at <http://www.whitehouse.gov/the-press-office/2013/07/15/executive-order-hiv-care-continuum-initiative>.

- List three innovative approaches that are used in your EIIHA plan, to address barriers to assessing testing and treatment which contribute to the HIV Care Continuum.
- List the collaborations you are pursuing within your EIIHA plan within the community and with other public health stakeholders to strengthen outcomes across the HIV Care Continuum.
- How are you using the EIIHA data to analyze or address any gaps along the HIV Care Continuum?

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

(e) Describe how the EIIHA Plan for FY 2015 (e.g., process, activities and outcomes) influenced the development of the EIIHA Plan for FY 2016.

(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 2016 EIIHA Plan. For each selected target population describe:

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

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

b. Unmet Need

Unmet Need is defined as the need for HIV primary medical care among individuals who know their HIV status but are not receiving such care. RWHAPs have historically used the Unmet Need Framework to estimate the number of PLWH not in care in their jurisdictions. For this FOA, a new methodology is being introduced which calculates unmet need based on the HIV Care Continuum. This Unmet Need Section will require grant recipients to compute unmet need estimates two ways (**Attachment 4**):

- Current methodology using the Unmet Need Framework to calculate Unmet Need for 2016, using CY 2014 data.
- New methodology using the HIV Care Continuum Framework to calculate an Unmet Need estimate for 2016, using CY 2014 data

Current Methodology: Unmet Need Framework Estimate

- (1) Provide an updated estimate of Unmet Need in your jurisdiction, using the HRSA/HAB Unmet Need Framework and calendar year (CY) 2014 data; include a copy of the framework as **Attachment 4** of this application.
- (2) Provide a table showing the percentage of Unmet Need for people living with AIDS (PLWA) and people living with HIV (PLWH) for CY 2012, 2013 and 2014 based upon the current methodology and data used for determining this estimate. Based on these estimates table, describe the trends in your Unmet Need percentages and to what you attribute these changes (e.g., increased outreach, increased linkages to care, increased number of low income PLWH). Also submit as **Attachment 4**.

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, viral load 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 2014 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 unmet need estimates derived from the current Unmet Need Framework and the new HIV Care Continuum. Specifically:

- (1) Describe any changes in the Unmet Need Estimate for FY 2016 (using CY 2014 data) resulting from deriving the estimate using the new HIV Care Continuum Framework. If no changes are identified, provide an explanation as to why.
- (2) If there is a difference, explain the difference; does it result in a smaller or larger estimate?
- (3) How does the estimate derived from the new HIV Care Continuum Framework align with the estimates for CY 2012, CY 2013, CY 2014 derived from the current Unmet Need framework?
- (4) Explain how the estimate derived from the HIV Care Continuum Framework would impact your approach to Unmet Need, and whether it would require your area to revise or modify its strategy for identifying the unmet need populations and their characteristics; strategies to link these populations back into care; and eliminate barriers to improving access to care.
- (5) Explain and describe the data used in the Unmet Need framework methodology versus the HIV Care Continuum framework methodology. Also, identify the values and sources of the data elements used in both estimates.

c. 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.

- (1) Identify service gaps within the jurisdiction;
- (2) Describe the method used to prioritize the service gaps; and
- (3) Describe how these service gaps will be addressed with FY 2016 Part A funding.

d. Minority AIDS Initiative

Under 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 Part A MAI is to improve “HIV-related health outcomes to reduce existing racial and ethnic health disparities.” As such, MAI funds provide direct financial assistance to Part A 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.

The goal of MAI, like the RWHAP, is viral load suppression. The MAI program, at the heart of its 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 be 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 President’s NHAS 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.
- (1) Identify minority populations based on epidemiological data (e.g., age, race, prevalence, gender) for your jurisdiction and the specific sub-groups (i.e., young African-American and Latino MSM; minority women receiving services at family planning clinics; substance users; and persons living with HIV who are leaving correctional facilities and re-entering communities) targeted with MAI funds.

- (2) Briefly describe up to two (2) MAI funded activities delivered to minority populations and sub-groups in your community that specifically address barrier reduction and identified needs of those communities with a special focus on eliminating and addressing health disparities and health inequities. Explain how these unique activities differ from other Part A services.
- (3) Describe the impact of MAI funded programs and/or activities on improving the HIV health outcomes amongst minority populations within the jurisdiction.

e. 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, jurisdictions and their health care systems must address a variety of co-morbidities and public health issues 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:

- (1) 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 (e.g., youth, women, YMSM, BMSM, etc.). Include information on how emerging populations were identified, unique challenges, and estimated costs to the Part A program (if applicable).
- (2) 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.
- (3) 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:**
 - (a) STI rates;
 - (b) Prevalence of homelessness;
 - (c) Formerly incarcerated;
 - (d) Mental illness;
 - (e) Substance abuse; and
 - (f) Hepatitis C Virus
- (4) 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.

f. 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 a [letter of clarification](#), was sent August 29, 2013, outlines the systemic requirements necessary to comply with the LPAP 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 for a complete list of LPAP requirements.

If you are planning to use funds for an LPAP, describe the following:

- (1) 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.
- (2) The component of the medication need that the LPAP will fill.
- (3) How the LPAP will be coordinated with the ADAP.
- (4) The client enrollment and eligibility process including how payer of last resort is ensured.
- (5) 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.
- (6) How the recipient ensures that the LPAP follows the most recent [HHS HIV/AIDS Treatment Guidelines](#).
- (7) 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

1) Impact of Funding

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

a. Impact of the Affordable Care Act

Through the Affordable Care Act, health insurance coverage options have been expanded for PLWH. These changes may affect health insurance coverage options in the jurisdiction, as well as Ryan White 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.

- i. **Uninsured and poverty:** Provide, in a table format, data on PLWH who are uninsured and living in poverty. 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 health care coverage; include those without Medicaid or Medicare; 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 your jurisdiction.
- ii. **Impact of health insurance expansion:** Describe the impact of the Affordable Care Act and insurance expansion on the Part A RWHAP. Describe how the implementation of the Affordable Care Act impacts both service costs and the complexity of providing care to PLWH in the EMA/TGA.
 - (1) In what ways are you continuing to serve PLWH who have gained coverage as a result of the Affordable Care Act?
 - (2) Are you paying the health insurance co-pays for these individuals or coordinating with the state to do so?
 - (3) For those individuals who are eligible for health insurance and received coverage under the Affordable Care Act, what are the major categories of service still being provided through your grant program (e.g., mental health services, substance abuse services, etc.)?
 - (4) As a result of potential resource shifts, in what ways are you now serving individuals who were not previously clients under the RWHAP Part A program (i.e., the general HIV/AIDS population within the jurisdiction, etc.)?
- iii. **Outreach and enrollment:** Describe efforts within the jurisdiction to conduct outreach to clients regarding health care coverage options and to vigorously pursue enrollment of Part A clients into health care coverage for which they may be eligible (e.g., Medicaid, private health insurance, etc.), as outlined in HAB Policy Clarification Notices 13-01 and 13-04 (<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>). Describe coordination efforts with other agencies and community partners.
- iv. **Marketplace options:** Provide an overall description of the plans available to PLWH and specify how they relate to the issue of provider accessibility and medications. Explain any challenges PLWH are experiencing or may experience in accessing care and medications.

- (1) What proportion of your population is having discontinuous or uncoordinated HIV/AIDS care as a side effect of gaining health care coverage, and losing access to certain providers or services?
- (2) How are you addressing the population described above (letter a) and providing continuous, comprehensive care along the HIV Care Continuum?

- v. **Successes/Outcomes:** Please document any successes/case studies and/or outcomes in terms of cost-savings, service provision, and meaningful outcomes (e.g., proportion of clients eligible for insurance coverage and the percent that received coverage under the Affordable Care Act).

b. 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:

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

2) 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 United States. Please refer to the recently released guidance on the submission of an integrated HIV prevention and care plan (<https://careacttarget.org/library/integrated-hiv-prevention-and-care-plan-guidance-including-statewide-coordinated-statement>).

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

a. Description of the Community Input Process

- i. Describe the over-all structure of your community input process; include a summary description of the priority setting and allocations process, and an explanation of how planning is linked to health outcomes along the HIV Care Continuum.
- ii. Describe the specific prioritization and allocation process and include the following:
 - (1) 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;
 - (2) How PLWH were involved in the planning and allocation processes and how their priorities were considered in the process;
 - (3) How the community input process was considered and addressed any funding increases or decreases in the Part A award;
 - (4) How MAI funding was considered during the planning process to enhance services to minority populations;
 - (5) How data were used in the priority setting and allocation processes to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the EMA/TGA;
 - (6) How changes and trends in HIV/AIDS epidemiology data were used in the planning and allocation process;
 - (7) How cost data were used in making funding allocation decisions;
 - (8) How data from other federally funded HIV/AIDS programs were used in developing priorities (refer to **Attachment 7** described below);
 - (9) How anticipated changes, due to the Affordable Care Act, were considered in developing priorities; and
 - (10) What efforts have or will be taken to integrate prevention and care planning at the Part A level.

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:

- i. That FY 2015 Formula, Supplemental, and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the PC or planning body;
- ii. That all FY 2015 Conditions of Award relative to the PC or planning body have been addressed;
- iii. That FY 2015 priorities were determined by the PC or planning body, and the approved process for establishing those priorities was used by the PC or planning body;
- iv. That annual membership training took place, including the date(s); and
- v. That representation is reflective of the epidemic in the EMA/TGA. If there

are any vacancies, provide a plan and timeline for addressing each vacancy. Note variations between the demographics of the non-aligned consumers and the HIV disease prevalence of the EMA/TGA.

c. Coordination of Services and Funding Streams

Part A EMA/TGA planning efforts should expand the availability of services, reduce duplication of services, and bring newly diagnosed PLWH into care or engage PLWH who know their status, but are not presently in the HIV/AIDS care system. 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.

- i. Provide in table format as **Attachment 7**, a presentation of other public funding and services provided in the EMA/TGA. The table should include the dollar amount(s) and the percentage of the total available funds in 2015, and the anticipated funds in 2016 for the following:
 - (1) Other RWHAP funding (Parts B, C, D, and F);
 - (2) Federal/state and local sources of public funding for HIV/AIDS; and
 - (3) HIV/AIDS-related service funds available in FY 2015 and anticipated in FY 2016.
- ii. Based on the table in **Attachment 7**, discuss how Part A funds are used to address any gaps in funding within the jurisdiction.

■ **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 2016. It should describe how Part A funded services are utilized to impact the HIV Care Continuum. The EMA/TGA system of HIV/AIDS care should be consistent with HRSA's goals of increasing access to services and decreasing HIV/AIDS health disparities among affected sub-populations and historically under-served communities.

1) Funding for Core and Support Services

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

a. FY 2016 Service Category Plan

The Service Category Plan utilizes core medical and support service categories that are prioritized and funded by the planning council or through local community planning processes. The plan consists of both Part A and MAI funds.

i. Service Category Plan Table

The service category table illustrates how 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 FY 2014, 2015, and 2016. For every service category funded by Part A in the jurisdiction, provide in table format the following (submit as **Attachment 8**):

- (1) 2014 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) 2015 service categories with priority number, allocated funding amount, and number of projected unduplicated clients to be served per the FY 2015 Implementation Plan submitted with the FY 2015 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) 2016 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.

ii. **Service Category Plan Narrative**

Based upon the FY 2016 Service Category Plan, provide a narrative that describes the following:

- (1) Identify any prioritized core medical services that will not be funded with FY 2016 RWHAP funds and how these services will be delivered in the EMA/TGA; (e.g., services funded by Medicaid, Medicaid expansion, Affordable Care Act, marketplaces, 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., Medicaid expansion, Affordable Care Act, increase/decrease in Part A award, changes in provider capacity, changes in available resources, new foci on the HIV Care Continuum, 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.

b. **Allocation Table**

Applicants must provide a separate Allocation Table that is reflective of the results of the priority setting and resource allocation process, **only if** those results are different from the Service Category Plan submitted as **Attachment 8**, reflecting

compliance with the 75 percent core medical services allocation requirement. In addition, applicants who are requesting a Core Medical Services (CMS) Waiver with this application must also submit an Allocation Table consistent with the waiver request. Applicants who were granted a FY 2016 CMS waiver prior to this application must submit the approved corresponding Allocation Table. (The Allocation Table and the CMS Waiver request, if applicable, should be included as **Attachment 9**.)

2) 2016 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 your Part A Program (e.g., implementing the Affordable Care Act, community engagement, etc.). Discuss challenges that have been encountered in integrating the HIV Care Continuum into planning and implementing the Part A program, and approaches that will be used to resolve such challenges.
- *EVALUATION AND TECHNICAL SUPPORT CAPACITY -- Corresponds to Section V's Review Criterion #3*

1) Clinical Quality Management (CQM)

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

CQM data play a critical role in documenting that services delivered to clients are improving their health status. Information gathered through the CQM program, as well as client-level health outcomes data, should be used as part of the EMA/TGA

planning process and ongoing assessment of progress toward achieving program goals and objectives, including improving the HIV Care Continuum . It should also be used by the grant recipient to examine and refine services based on outcomes and the cost of delivering quality care.

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

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

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

a. Description of CQM Program Infrastructure:

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

b. Description of CQM Program Performance Measures:

- i. List the performance measures for each service category which the applicant funds.
- ii. Describe the frequency of performance measure data collection from subrecipients.
- iii. Summarize the performance measure data collected for outpatient/ambulatory medical care and medical case management from the last period of performance or calendar year, including any trending data.
- iv. Describe how performance measure data are analyzed to evaluate for disparities in care, and actions taken to eliminate disparities.
- v. Describe how stakeholders, including subrecipients, consumers, and other RWHAP recipients in the jurisdiction and planning council/body contribute to the selection of performance measures and receive information about performance measure data.

c. Description of CQM Program Quality Improvement:

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

d. Data for Program Reporting

- i. Name and describe the information/ data system(s) within the EMA/TGA used for data collection and reporting operations.
- ii. Describe the grant recipient's current client level data collection capabilities included in the Ryan White Service Report (RSR). Include the percentage of subrecipients that were able to report CY 2014 client level data. Describe efforts to increase data completeness and validity.

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

1) Grant Administration

The purpose of this section is to demonstrate the extent to which the chief elected official (CEO) or designee in the EMA/TGA has met the legislative requirements to disburse funds quickly, closely monitor their use, and ensure the 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 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:

- 1. The future year award is reduced by the amount of UOB, less the amount of approved carryover; and*
- 2. 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 will 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.

a. Program Organization

- i. Provide a description of how Part A funds are administered within the EMA/TGA with reference to the staff positions, including program and fiscal staff, described in the budget narrative and the organizational chart provided in **Attachment 11**. The narrative should describe: the local agency responsible for the grant and identify the entity responsible for administering the Part A Program, including the department, unit, staffing levels (FTEs, including any vacancies), fiscal agents, PC/planning body staff, and in-kind support staff. Describe the approaches to fill vacant staff positions that are essential for delivery, oversight, and monitoring of the Part A and MAI services/activities.
- ii. 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.

b. Grant Recipient Accountability

HRSA/HAB holds recipients accountable for the expenditure of funds awarded under 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 outlined in the Uniform Guidance - [Subrecipient Monitoring and Management](#) (45 CFR §75.351 and 352).

- i. **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 2015; 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 2015 to date and a summary of the corrective actions planned or taken to address these findings;

- (5) The number of subrecipients that have received technical assistance (TA) for FY 2015, to date (types of TA, scope, and timeline).

ii. **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 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.

c. **Administrative Assessment**

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

- i. Provide a narrative that describes the results of the PC or planning body's assessment of the administrative mechanism in terms of:
 - (1) Assessment of grant recipient activities to ensure timely allocation/contracting of funds and payments to contractors; and
 - (2) 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?

d. **Third Party Reimbursement**

The RWHAP is the payer of last resort, and recipients must make every effort to ensure that alternate sources of payments are pursued and that program income is used consistent with grant requirements. HRSA expects recipients to screen for proof of insurance status and financial eligibility for use of funds on a regular basis (see <http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>). Recipients and subrecipients are required to use effective strategies to coordinate between Part A and third party payers who are ultimately responsible for covering the cost of services provided to eligible or covered persons. Third party sources include Medicaid and any opportunities for expansion under the Affordable Care Act, Children's Health Insurance Programs (CHIP), Medicare, including Medicare Part D, and private insurance, including new options available under the health

insurance marketplace established by the Affordable Care Act. Subrecipients providing Medicaid eligible services must be Medicaid certified.

- i. Provide a narrative that describes the following:
 - (1) 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;
 - (2) The process to conduct screening and eligibility to ensure the RWHAP is the payer of last resort; and
 - (3) 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, section 2605(a)(1)(B) of the PHS Act, requires 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 one-year period preceding the FY for which the grant recipient is applying to receive a Part A award. After enactment of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Section 2604(b)(1) of the PHS Act states: “In general – The chief elected official of an eligible area shall use amounts from a grant under Section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services.” Core medical services and support services are defined in Section 2604(c)(3) and 2604(d) of the PHS Act and HAB’s service definitions distributed to all recipients. Part A recipients must document that they have met the MOE requirement.

To demonstrate that recipients understand this revision to the documentation necessary to fulfill the Part A MOE requirement, applicants must submit the following information as **Attachment 12**:

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

NARRATIVE GUIDANCE

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.

<u>Narrative Section</u>	<u>Review Criteria</u>
Introduction	(1) Need
Needs Assessment	(1) Need
Methodology	(2) Response and (4) Impact
Work Plan	(2) Response
Resolution of Challenges	(2) Response
Evaluation and Technical Support Capacity	(3) Evaluative Measures
Organizational Information	(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 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 Ryan White Part A HIV Emergency Relief Grant Program requires the following:

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

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

- (1) “Administrative”
- (2) “Clinical Quality Management”
- (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 planning council 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 or planning body mandated functions within the administrative line item. Planning Council/planning body support should cover *reasonable and necessary costs* associated with carrying out legislatively mandated functions.

The Consolidated and Further Continuing Appropriations Act, 2015, Division G, § 203, (P.L. 113-235) 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 will apply in FY 2016, as required by law.

iv. Budget Justification Narrative

See Section 4.1.v. of HRSA’s [SF-424 Application Guide](#). In addition, the Ryan White Part A HIV Emergency Relief Grant Program requires the following:

In addition to the SF-424A, submit a budget narrative in table format as **Attachment 13**. The budget narrative table should explain the amounts requested for each line in the budget by column headings listed, and explain how the line items listed support the overall Part A HIV service delivery system. The budget narrative table should clearly state how each object class category’s efforts and/or activities make a contributing impact to support the Part A HIV service delivery system. Include a justification column that clearly explains the activities which impact the Part A HIV service delivery system. In addition, the annual salary, program FTE and program salary subtotal must be listed for each personnel with adequate justification clearly explaining how the roles impact the Part A HIV service delivery system.

Caps on expenses: Part A Grant Administration Costs (including Planning Council or planning body support) may **not** exceed 10 percent of the grant award. Administrative expenditures for first- line entities or subrecipients may **not** exceed 10 percent of the aggregate amount allocated for services. Recipients are allowed to allocate up to five percent of the total grant award or \$3,000,000 (whichever is less), for CQM activities.

Administrative Costs are those costs associated with the administration of the Part A grant. By law, no more than 10 percent of the Part A budget can be spent on administrative costs. 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 has entered into a vendor or procurement relationship with the recipient, and 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 healthcare services for the lead agency are considered to be first-tier entities

(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 Policy Clarification Notice (PCN) 15-01

(<http://hab.hrsa.gov/affordablecareact/pcn1501.pdf>) and Frequently Asked Questions (<http://hab.hrsa.gov/manageyourgrant/faqpolicyclarificationnotice15-01.pdf>).

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

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

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

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

- Salaried personnel, contracted personnel or visit fees to provide core medical services directly to the HIV-infected client, including primary medical care, laboratory testing, oral health care, outpatient mental health, medical nutrition therapy, outpatient substance

abuse treatment, specialty and subspecialty care. Provider time must be reasonable for the number of clients.

- Lab, x-ray, and other diagnostic tests.
- Medical/dental equipment and supplies.
- Other clinical and diagnostic services regarding HIV/AIDS and periodic medical evaluations of individuals with HIV/AIDS, according to the HHS guidelines. <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 insurance plans through the health insurance marketplaces/exchanges, and benefits counseling. Services are generally provided to clients who are new to care.
- Salaried or contracted personnel that 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, marketplaces/exchanges, Medicare Part D, State Pharmacy Assistance Programs, and other state or local health care and supportive services). Services are provided to prevent clients from falling out of care.

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

- Salaried personnel, contracted personnel, or visit fees to provide support services directly to the HIV-infected or affected client;
- Salaried or contracted personnel that 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 are provided to prevent clients from falling out of care. Referrals for health and supportive services are generally provided to clients who have a change in insurance status, new eligibility, or require a change in treatment regimen;
- Salaried or contracted personnel that provide outreach to and enrollment of RWHAP clients into health insurance coverage as a component of case management services; this may include benefits/entitlement counseling and referral activities as allowable activities. Services are provided to prevent clients from falling out of care;
- Peer to peer education/support;
- Patient navigators/community health worker aide; and
- Local travel by staff to provide support services.
- Under certain **limited circumstances**, rent may be an allowable direct service expense:
 - 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 HRSA's [SF-424 Application Guide](#))

Attachment 2: Letters of Agreement, Memorandum of Understanding, Intergovernmental Agreements, FY 2016 Agreements and Compliance Assurances, Certifications (required)
In addition to completing the SF-424B Assurances per instructions in HRSA's [SF-424 Application Guide](#), also complete and submit the required Part A Grant Program FY 2016 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 presentation of other public funding and services provided in the EMA/TGA. The table should include the dollar amount(s) and the percentage of the total available funds in 2015, and the anticipated funds in 2016 for the following:

- a) Other RWHAP funding (Parts B, C, D, and F);
- b) Federal/state and local sources of public funding; and
- c) HIV/AIDS-related service funds available in FY 2015 and anticipated in FY 2016.

Attachment 8: FY 2016 Service Category Plan Table (required)

Attachment 9: Allocation Table, Core Medical Services Waiver Request (if applicable)

Attachment 10: FY 2016 HIV Care Continuum Work Plan (required)

Attachment 11: Organizational Chart (required)

Attachment 12: Maintenance of Effort Documentation (required)

Provide a table that identifies the MOE budget elements and the amount of expenditures related to HIV/AIDS core medical and support services for the applicant's two most recently completed fiscal years prior to the application deadline. 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. Also include a description of the process and elements used to determine the amount of expenditures in the MOE calculation.

Attachment 13: Budget Narrative Table (required)

Attachment 14: Federally Negotiated Indirect Cost Rate Agreement (if applicable, not counted in the page limit).

Attachments 15: 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 Universal Numbering System (DUNS) Number and System for Award Management

Applicant organizations must obtain a valid DUNS number and provide that number in their application. Each applicant 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 it has 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 an applicant/recipient organization has 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 *November 2, 2015 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 Ryan White Part A Emergency Relief Grant Program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. See Executive Order 12372 in the [HHS Grants Policy Statement](#).

See Section 4.1 ii of HRSA’s [SF-424 Application Guide](#) for additional information.

6. Funding Restrictions

Applicants responding to this announcement 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 clients;
- 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;
- Pre-Exposure Prophylaxis (PrEP) or non-occupational Post-Exposure Prophylaxis (nPEP) – Ryan White HIV/AIDS Program funds cannot pay for PrEP or nPEP, as the person using PrEP or nPEP is not HIV infected, and therefore is not eligible for Ryan White HIV/AIDS Program funded medication; and
- Payment for any item or service to the extent that payment has been made (or reasonably can be expected to be made), with respect to that item or service, under any state compensation program, insurance policy, federal or state benefits program, or any entity that provides health services on a prepaid basis, (except for a program administered by or providing the services of the Indian Health Service).

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 G of the Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235) 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 2016, as required by law.

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 Part A, allowable costs are limited to core medical services, support services, clinical quality management 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 clinical quality management 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.

V. Application Review Information

1. Review Criteria

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

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

Review Criteria are used to review and rank applications. The RWHAP Part A Program has six (6) review criteria:

Criterion 1: NEED (66 points) – Corresponds to Section IV's ii, Project Narrative: Introduction, Needs Assessment/Jurisdictional Profile, HIV Care Continuum, Demonstrated Need and associated attachments. Note: This section includes EIIHA which is 33 points, per legislation.

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

1) Jurisdictional Profile (4 points)

- (1) HIV/AIDS Epidemiology Table uses most recent data available and clearly cites sources of data.
- (2) HIV/AIDS Demographic Table (**Attachment 3**) uses most recent data available and clearly cites sources of data.

2) HIV Care Continuum for FY 2016 (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 activities targeted to address significant health disparities (if any) identified among populations within the jurisdiction's HIV Care Continuum.
- d. Evidence of a thorough understanding of barriers or unique challenges in developing and utilizing the HIV Care Continuum model in the Part A program and the strength of activities developed to address these barriers or challenges.

3) **Demonstrated Need (56 points)**

A. Early Identification of Individuals with HIV/AIDS (EIIHA 33pts)

EIIHA Data (14 pts)

- (1) For the selected three target populations, the extent to which the applicant provided the following complete data for January 1, 2015 – June 30, 2015:

Newly diagnosed positive HIV test events

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

Previously diagnosed positive HIV test events

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

FY16 EIIHA Plan (19 pts)

- (1) The strength and feasibility of the EMA/TGA's EIIHA Plan for FY 2016 as evidenced by:
 - a. The updated estimate of individuals who are HIV positive and who are unaware of their status, and the strength of the estimate methodology;
 - b. Inclusion of all populations for the EIIHA Plan;

- c. The primary activities that will be undertaken, including system level interventions e.g. routine testing in clinical settings, expanding partner services;
 - d. Major collaborations with other programs and agencies, including HIV prevention and surveillance programs; and
 - e. Planned outcomes of the overall EIIHA strategy.
- (2) The extent to which the proposed FY 2016 EIIHA Plan contributes to the goals of the National HIV/AIDS Strategy.
 - (3) The extent to which the proposed FY 2016 EIIHA Plan contributes to the goals of the White House HIV Care Continuum Initiative.
 - (4) The extent to which the EIIHA planned activities addresses the Unmet Need estimate population.
 - (5) Evidence that the EIIHA Plan for FY 2015 (e.g. process, activities and outcomes) influenced the development of the EIIHA Plan for FY 2016.
 - (6) If applicable, the strength and feasibility of planned efforts to remove legal barriers, including State laws and regulations, to routine HIV testing.
 - (7) The appropriateness of the three (3) distinct target populations selected for the FY 2016 EIIHA Plan as evidenced by:
 - a. Why the target population was chosen and how the epidemiological data, Unmet Need estimate data, or other data supports that decision;
 - b. Specific challenges with or opportunities for working with the targeted population;
 - c. Specific activities that will be utilized with the target population;
 - d. Specific objectives for each component of EIIHA (identify, inform, refer, and link to care) for the target population (all objectives should be written as S.M.A.R.T objectives – **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**ime phased);
 - e. The responsible parties, including any coordination with other agencies and/or programs for ensuring each of the activities are implemented, and their respective roles;
 - f. Planned outcomes that will be achieved for the target population as a result of implementing the EIIHA Plan activities.
 - (8) The strength of proposed plans to present, discuss, and/or disseminate the EIIHA Plan, and outcomes of the EIIHA Plan activities to stakeholders.

B. Unmet Need (8 points)

- (1) The clarity and completeness of the applicant's Unmet Need framework estimates (**Attachment 4**) supported by data sources and calculations.

- (2) The extent to which the table, based on the current methodology, showing the percentage of Unmet Need for PLWA and PLWH is clear, complete, and consistent with the trends described in the narrative. The extent to which the narrative demonstrates an understanding of the trends in the Unmet Need percentages and what contributed to those trends.
- (3) The clarity of the Unmet Need estimate table using the HIV Care Continuum framework (**Attachment 4**) and explanation of any changes/differences between the two 2016 calculations (current and new methodologies).
- (4) A clear explanation of how the estimate derived from the HIV Care Continuum framework aligns with estimates for CY12, CY13, and CY14.
- (5) A clear explanation of the impact on the approach to Unmet Need based on the estimate derived from the HIV Care Continuum.
- (6) The strength and clarity of the data used in the Unmet Need and HIV Care Continuum framework estimates.

C. Service Gaps (3 points)

- (1) 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 Part A funding.

D. Minority AIDS Initiative (6 points)

- (1) The extent to which the applicant clearly identified minority populations based on data presented in the epidemiology table, narrative on new/emerging populations, if applicable (FOA page 19), and specific sub-groups targeted with MAI funds.
- (2) The extent to which activities described clearly address barrier reduction and identified needs of the communities with an explanation of how these activities differ from other Part A services.
- (3) The impact of MAI funded programs and/or activities on improving health outcomes among minority populations within the jurisdiction.

E. Special Populations and Complexity of Providing Care (6 points)

- (1) The extent to which the applicant demonstrates a thorough understanding of the disproportionate impact on emerging (if applicable) and under-represented populations.
- (2) 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's, 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.

1) Planning and Resource Allocation (6 points)

A. Strength of the Community Input Process (3 points)

- (1) The strength of the planning process in the EMA or TGA as evidenced by community input, priority setting, and allocations processes.
- (2) Evidence that the prioritization and allocation process addresses the data and information presented in the Need section of the application.
- (3) 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.
- (4) The extent to which PLWH were involved and evidence that their priorities were considered in the planning and allocation process.
- (5) The extent to which MAI funding was considered during the planning process.
- (6) The extent to which anticipated changes due to the Affordable Care Act were considered in developing priorities.

B. The Letter of Assurance or Concurrence signed by the PC chair(s) or planning body leadership fully addressed the following components (Attachment 6) (1 point):

- (1) The FY 2015 formula, supplemental, and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the PC;
- (2) That all FY 2015 Conditions of Award relative to the PC have been addressed;
- (3) The FY 2015 priorities were determined by the PC, and the approved process for establishing those priorities was used by the PC;
- (4) Date that the annual membership training took place; and
- (5) Representation is reflective of the epidemic; if there are vacancies, a plan and timeline to address each vacancy; if applicable, noted variations between demographics of non-aligned consumers and HIV disease prevalence of the EMA or TGA.

C. Coordination of Services and Funding Streams (2 points)

- (1) 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 2015, and the anticipated funds in 2016 for the following:

- a. other Ryan White HIV/AIDS Program funding (Parts B, C, D, and F);
- b. federal/state and local sources of public funding for HIV/AIDS; and
- c. HIV/AIDS-related service funds available in FY 2015 and anticipated in FY 2016.

- (2) Based on the data in Attachment 7, the strength and feasibility proposed use of Part A funds to address any gaps in funding within the jurisdiction.

2) Funding for Core and Support Services (6 points)

A. FY 2016 Service Category Plan (Attachment 8) (4 points)

- (1) The clarity and completeness of the table that illustrates how 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 FY 2014, 2015, and 2016.

- (2) The comprehensiveness and strength of the FY 2016 Service Category Plan. The extent to which the narrative expands and clarifies the information presented in the Plan and addresses the following:

- a. Prioritized core medical services that will not be funded with FY 2016 Ryan White HIV/AIDS Program funds and how these services will be delivered in the EMA/TGA; (e.g., services funded by Medicaid, Medicaid expansion, Affordable Care Act marketplaces, CHIP, etc.);
- b. How the activities described in the Plan will promote parity of HIV services throughout the EMA. Parity of services should be addressed in terms of geographic location of services, quality, comprehensiveness of services;
- c. How planned activities assure that services delivered by providers are culturally and linguistically appropriate to the populations served within the EMA/TGA;
- d. Factors that contributed to changes in funding within the service categories (e.g., Medicaid expansion, Affordable Care Act, increase/decrease in Part A award, etc.);
- e. 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
- f. How any changes to service categories are linked to needs assessments or updates (including Unmet Need or new initiatives).

B. Allocation Table (2 points)

- (1) The strength and clarity of the Allocation Table and Core Medical Services Waiver request, if applicable (**Attachment 9**).

3) Resolution of Challenges (2 points)

The strength and feasibility of approaches to resolve challenges and barriers identified throughout the application (e.g., Affordable Care Act implementation, community engagement, etc.), as well as challenges encountered in integrating the HIV Care Continuum into planning and implementing the Part A program.

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

1) Clinical Quality Management (COM) (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 Ryan White recipients in jurisdiction.
- (2) Performance measurement: The strength of performance measurement as evidenced by performance measures for each service category 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 subrecipients; 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's, ii, Project Narrative: Methodology/Impact of Funding and associated attachments.

1) Impact of Funding (5 points)

A. Impact of the Affordable Care Act (3 points)

- (1) The clarity and completeness of the table with available data on PLWH who are uninsured and living in poverty in their jurisdiction.
- (2) 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.

B. Impact and Response to Reduction in Ryan White HIV/AIDS Program Formula Funding (2 points)

- (1) The extent to which the applicant demonstrated a thorough understanding of both the impact and response to funding reduction (if applicable).

Criterion 5: RESOURCES/CAPABILITIES (5 points) – Corresponds to Section IV's, 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. As HRSA-16-021 represents competing continuation awards, past performance will also be considered as per the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR part 75), which includes History of Performance (section 75.205(c)(3)).

1) Grant Administration (5 points)

A. Program Organization (2 points)

- (1) The capacity of the local agency responsible for the grant and the entity responsible for administering the 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);
- (2) The strength and viability of the process and mechanisms, including data collection, used to ensure providers funded through multiple Ryan White HIV/AIDS Program Parts (i.e., Parts A, B, C, D, and F) distinguish which clients are served by each individual funding stream to avoid duplication of services.

B. Recipient and Subrecipient Accountability (3 points)

Program Oversight

- (1) The strength and feasibility of the steps taken by the EMA/TGA in 2015 to implement the National Monitoring Standards;
- (2) 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
- (3) The strength and appropriateness of corrective actions planned or taken to address programmatic findings in FY 2015, as well as the appropriateness of the number of subrecipients that received TA in FY 2015, to date (given the types, scope, and timeline of TA).

C. Fiscal Oversight

- (1) 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.
- (2) The strength of the process used to separately track formula, supplemental, MAI, and carryover funds, including data systems utilized, and the process used to ensure timely monitoring and redistribution of funds.
- (3) 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.
- (4) 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's ii, Project Narrative: Organizational Information, MOE, Budget and associated attachments.

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

1) Budget and Maintenance of Effort (MOE) Documentation

- (1) The reasonableness and completeness of the SF 424A for each year of the project period, with the required categories.
- (2) The clarity and strength of the budget justification, with descriptions that explain the amounts requested for each line in the budget as it relates to the needs described in the Need section.
- (3) The clarity and completeness of the documentation describing EMA/TGA compliance with the MOE legislative requirement, as supported by the MOE Table, included with the application.

2. Review and Selection Process

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

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

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of March 1, 2016.

VI. Award Administration Information

1. Award Notices

The Notice of Award will be sent prior to the start date of March 1, 2016. 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 recipient 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 recipient 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 recipient must submit a table on Part A and MAI expenditures; further information will be provided in the notice of award.
- 5) **Ryan White Services Report.** The recipient must comply with data requirements of the Ryan White Services Report (RSR) and that mandate compliance by each of its subrecipients. The RSR captures information necessary to demonstrate program performance and accountability.
- 6) **Client level Data Report.** All Ryan White HIV/AIDS Program core services and support services providers are required to submit client level data for CY 2015. Please refer to the HIV/AIDS Program Client Level Data website at <http://hab.hrsa.gov/manageyourgrant/clientleveldata.html> for additional information.
- 7) **Waiver to Request Carryover.** The Ryan White HIV/AIDS Program legislation requires a waiver to request carryover of unobligated formula funds before the end of the period of performance. A carryover waiver application, together with the estimated unobligated balance (UOB), must be submitted to HRSA/HAB, stating the purpose for which such funds will be expended during the carryover year, no later than December 31, (with an automatic extension to the first workday following December 31, if it is a weekend or holiday).

VII. Agency Contacts

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

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

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

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

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

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

Successful applicants/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:

All applicants are encouraged to participate in a technical assistance (TA) webinar for this funding opportunity. The technical assistance webinar is tentatively scheduled for September 24, 2015 from 2-4PM Eastern Time. The purpose of this webinar is to assist potential applicants in preparing applications that address the requirements of this funding announcement. Participation in a pre-application TA webinar is optional.

Information for the September 24, 2015, 2:00-4:00 EST Webinar on the Part A 2016 Application TA National Call is:

Adobe Connect URL Website:
https://hrsa.connectsolutions.com/pre-app_ta_2016/

Dial-in audio line:
1-877-779-7419
Passcode: 7898318#

IX. Tips for Writing a Strong Application

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

Appendix A

FY 2016 AGREEMENTS AND COMPLIANCE ASSURANCES

Ryan White HIV/AIDS Program

Part-A Grant Program

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

Pursuant to Section 2602(a)(2)^{1, 2}

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

Pursuant to Section 2602(a)(2)(B)

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

Pursuant to Section 2602(b)(4)

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

Pursuant to Section 2603(c)

The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)

The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council/Planning Body.

Pursuant to Section 2604(a)

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

² 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.

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 5 percent of program funds or \$3 million.

Pursuant to Section 2604(i)

The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)

With regard to the use of funds,

- a. funds received under Part A of Title XXVI of the PHS Act will be used to supplement, not supplant, state funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease;
- b. during the 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