

Request for Professional Services (RPS) Informational Meeting

Date: January 7, 2020

Time: 10am-11:30am

6th Floor Conference Room

Hasbrook Building

Marion County Public Health Department

3838 N. Rural St.

Indianapolis, IN 46205

Attendance is strongly encouraged, but is not required for applicant agencies.

Date: December 26, 2019

From: Michael Butler, Director
Ryan White HIV Services Program
Marion County Public Health Department

Re: Proposals for Professional Services

The Marion County Public Health Department is seeking Proposals for Professional Services for service provision under the Ryan White Part A/MAI Program for funding cycle 2020-2022. Funding is offered under two distinct funding categories; Part A HIV Services with anticipated available funding of \$3,706,167 and MAI (Minority AIDS Initiative) with anticipated available funding of \$262,385. The purpose of Part A funding is to provide direct financial assistance to a Transitional Grant Area (TGA) “that has been severely affected by the HIV epidemic”. The purpose of MAI funding is to “improve HIV- related health outcomes to reduce existing racial and ethnic health disparities”. The TGA identified priority MAI populations are African Americans and Hispanics. The Budget for 2020-2021 is to be for a 12-month period. This will be the second 12-month period for this 3-year contract. Future funding may be conditioned upon the successful completion and submission to HHC of annual progress reports detailing goals and objectives and fiscal utilization of funds. Proposals will be accepted in accordance with the schedule set out in the enclosed proposal guidelines. Please note that forms are included which are required to be submitted with a funding request. Grant funds will be available March 1, 2020.

Proposals must be received no later than 12:00P.M. (Noon), January 28, 2020. You may mail or hand-deliver one complete original proposal along with four (4) copies to:

Michael Butler, Director
Ryan White HIV Services Program
Marion County Public Health Department
2951 East 38th St., Suite 203
Indianapolis, IN 46218

It is essential that all requested information is received by the deadline date and time. Proposals received after the deadline will not be considered for funding.

If you have questions regarding this request for proposals, please contact:

Michael Butler, Director
Ryan White HIV Services Program
Marion County Public Health Department
317/221-3554
mibutler@marionhealth.org

Please feel free to share with agencies in your area or service region.

**Health & Hospital Corporation of Marion County
doing business as (dba)
Marion County Public Health Department
Ryan White Part A/MAI Program**

Dates of Service Provision

March 1, 2020 through February 28, 2021

SUBMISSION DEADLINE

One original and four copies (five in total) must be received by:

Date: January 28, 2020

Time: 12:00 pm (Noon)

Send or deliver to:

Michael Butler, Director

Ryan White HIV Services Program

Marion County Public Health Department

2951 E. 38th St., Suite 203

Indianapolis, IN 46218

**Health and Hospital Corporation of Marion County
dba
Marion County Public Health Department
Ryan White Part A/MAI Program
Request for Professional Services**

**Section 1.0: General Information, Requested Proposals for Professional Services (RPS),
General Program Requirements**

1.1 Introduction

The Health and Hospital Corporation of Marion County (HHC) dba Marion County Public Health Department (MCPHD) is requesting proposals from qualified public or private non-profit health and support service providers (respondents) to provide core medical and supportive services to persons living with HIV/AIDS in the Indianapolis Transitional Grant Area (TGA). Counties included in the TGA are: Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam, and Shelby.

Ryan White Part A and the Minority AIDS Initiative (MAI) are federal initiatives that provide funding to core (medical) and supportive service providers who offer low-cost comprehensive health and social services to individuals infected or affected by HIV. The U.S. Department of Health and Human Services (HHS) through the Health Resources and Services Administration (HRSA) funds Ryan White Part A and MAI. The Ryan White Part A/MAI Program operates in accordance with federal and state policies and under the administrative and financial policies of HHC through its Public Health Division, MCPHD.

1.2 Purpose of the Proposal for Professional Services

The purpose of this proposal request is to select respondents that satisfy HHC/MCPHD's requirements to provide core and supportive services to eligible and enrolled individuals living with HIV/AIDS in the Indianapolis TGA. It is anticipated that HHC/MCPHD will enter into more than one contractual agreement as a result of this process. The term of the contract to be awarded is for a 12-month period which shall commence March 1, 2020 and continue through February 28, 2021. Contracts may be renewed for one additional year should respondents meet performance requirements.

1.3 Philosophy of Service Delivery

To ensure comprehensive care, successful respondents will be required to function as part of a coordinated service delivery system; adhere to the National Monitoring Standards for Ryan White sub-recipients and to the RWSP Standards of Care for HIV Services for the Indianapolis TGA; and ensure that Ryan White funds are used as the Payer of Last Resort. In addition, respondents will be required to participate in staff training and development; track patients who have fallen out of care and devise a policy by which to bring patients back into care; agree to make referrals to other approved Ryan White providers, when appropriate; and facilitate linkage and entry into care within the Ryan White provider network. Respondents should maintain an overall philosophy of cultural and linguistic competency, inclusion and non-discrimination to service providers, minorities, persons living with HIV/AIDS, and the public.

1.4 No-Show Rule

Successful respondents have the right to suspend, temporarily or permanently, any or all services to clients who habitually miss provider appointments (defined as three or more). Successful respondents who wish to use the “no-show rule” must include the rule in their client agreement (consent to receive services) form and the form must be signed by the client.

1.5 Priorities and Service Provision Requirements

The services included in this proposal request will be provided with priority to medically underserved, indigent individuals who are infected with HIV (or, for delivery of testing services, at risk for infection), reside in the Indianapolis TGA, and who meet current Federal Poverty Level (FPL) guidelines. These services will be assessed on a sliding-fee scale according to FPL guidelines. Ryan White Part A/MAI funding is considered to be the Payer of Last Resort.

1.6 Eligibility for Consideration of Funding

- **Non-Profit Status**

Public or private non-profit agencies are eligible to apply for funding through the Ryan White Part A/MAI Program. Non-profit service providers must demonstrate proof of non-profit status by submitting appropriate documentation (i.e., a Letter of Determination issued by the Internal Revenue Service) in the name of the proposing agency and any partnering agencies as part of the proposal. Failure to provide said documentation will deem the proposal ineligible for consideration.

- **Medicaid Certification**

In accordance with National Part A Fiscal Monitoring Standards:

- Respondents who apply for Ryan White Part A/MAI funding to provide services that are Medicaid reimbursable are required to be certified to receive Medicaid payments or to describe their efforts to obtain certification for each service for which they are applying. Documentation of current efforts to become certified for the requested services, including a timeline, must be attached at the end of the application. Failure to comply with this standard will prohibit funding for that service.
- If respondents have been funded for a Medicaid eligible service for more than two consecutive years, they must demonstrate that they are currently billing Medicaid. (Documenting application for Medicaid is no longer sufficient in this situation). If respondents do not have the capacity to bill after this time, they will not be funded to provide the service until such time that documentation from Medicaid allowing billing is received by the RWSP. If there are extenuating circumstances delaying the authorization from Medicaid, respondents will need to present this to the RWSP for funding determination. These instances will be considered on an individual basis.
- If funded for Medicaid reimbursable services, respondents must document and maintain files of their Medicaid status, including any agreements with Medicaid managed care companies.

Services which are eligible and ineligible for billing through Medicaid are listed below. In addition, Medicaid billing eligibility is indicated for each service listed in Section 7.0: Services Eligible for Funding 2020-2021.

Medicaid Billing Eligible	Not Medicaid Billing Eligible
AIDS Pharmaceutical Assistance (Local)	Early Intervention Services (EIS)
Emergency Financial Assistance (Pharmacy)	Emergency Financial Assistance (Food, Utilities, Housing)
Medical Transportation	Health Education/Risk Reduction (HE/RR)
Mental Health Services	Health Insurance Premium And Cost Sharing Assistance
Oral Health Care	Legal Services
Outpatient/Ambulatory Health Services	Linguistics Services
Substance Abuse Outpatient Care	Medical Case Management
Substance Abuse Services (Residential)	Medical Nutrition Therapy
	Non-Medical Case Management
	Outreach Services
	Psychosocial Support Services

- **National Monitoring Standards**

All respondents who apply for Part A/MAI funding must agree in writing to comply with the National Monitoring Standards for Ryan White HIV/AIDS Part A and Part B Grantees (see Section 3.2: Cover Letter). This includes the universal, fiscal, and programmatic standards. The standards document may be obtained from <http://hab.hrsa.gov/manageyourgrant/granteebasics.html> or by contacting the RWSP. Failure to comply with these standards will prohibit future funding eligibility.

- **Indianapolis TGA Standards of Care**

If funded, respondents must be able to meet all elements outlined in the TGA standards of care for each service for which funding is granted. The standards document may be obtained here http://www.ryanwhiteindynga.org/File/Standards_of_Care_-04-28-2017-Final.pdf or by contacting the RWSP. Failure to comply with these standards will prohibit future funding eligibility.

- **E-Verify**

- Employment Eligibility Verification is required by Indiana Code 22-5-1.7-11.
- Effective July 1, 2011, government agencies and vendors providing services to government agencies are required by law to utilize E-Verify for the purposes of

determining the employment eligibility status of all new employees. See <https://www.e-verify.gov/>.

- No agency will be awarded a contract for services if they do not sign and include in their application a signed affidavit affirming compliance with this law. See *Attachment A* for the affidavit and contract provision.

- **Access to Care for Indianapolis TGA Eligible and Enrolled Clients**

Respondents must clearly demonstrate their ability to provide the service(s) to any eligible and enrolled client residing anywhere within the ten county TGA before consideration of funding will be given.

- **Application for MAI funding**

Respondents seeking funding to serve MAI populations must clearly describe their history of working with the selected population(s). Respondents must demonstrate in their proposal success at engaging the population(s) in services and achieving successful outcomes through service provision.

- **History of Satisfactory Performance**

Respondents who have previously been awarded Ryan White Part A/MAI funds must have no record of unsatisfactory performance. Respondents whose performance is or has been seriously deficient, including contract termination, during either the current funding period or within the last three years, in the absence of circumstances properly beyond the control of the respondent, shall be presumed to be unable to meet this requirement.

- **Administrative and Fiscal Capability**

Respondents must have the administrative and fiscal capability to provide and manage their proposed services and to ensure adequate tracking for audit purposes. Respondents must have the ability to begin delivering proposed services by March 1, 2019.

- **Whistleblower Protection**

Recipients of federal grant funds are subject to the Whistleblower Protection Programs (<https://www.whistleblowers.gov/>) and Whistleblower Protection Enhancement Act of 2012. This program requires federally funded agencies to inform their employees working under this agreement that they are subject to the whistleblower rights and remedies of the Whistleblower Protection Program. Employee notification of whistleblower protections including, but not limited to, the protection that an employee of a federally funded agency may not be discharged, demoted, or otherwise discriminated against as a reprisal for whistleblowing, must be provided in writing and in the predominant native language of the workforce. Whistleblower protections cannot be waived by any agreement, policy, form, or condition of employment.

1.7 Required Policies and Procedures

1.71 Non-Discrimination

Respondents must ensure that services provided under this RPS will be available to eligible and enrolled clients, regardless of race, ethnicity, gender, sexual orientation, religion, national origin, or disability. A policy of non-discrimination must be conspicuously posted in the respondent's

offices and clearly indicated in public information materials, employment applications, and personnel policies.

1.72 Grievance Policy Procedure

Respondents must have written policies and procedures in place for addressing grievances of both clients and employees. Procedures pertaining to clients must be available and visible to clients in the office setting. These will be subject to review at the time of each RWSP site visit.

1.73 Accountability for Expenditure of Funds

Successful respondents are required to establish and implement the following items to ensure accountability for expenditure of Part A/MAI funds:

- Fiscal and general policies and procedures that include compliance with federal and Ryan White programmatic requirements;
- Flexible fiscal reporting systems that allow the tracking of unobligated balances and carryover funds and detail service reporting of funding sources; and
- Timely submission of independent audits (A-133 audits, if required) to the RWSP.

Part A funds may **not** be used for the following purposes:

- Development of materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual;
- Purchase of vehicles without written Grants Management Officer (GMO) approval;
- Marketing promotions or advertising about HIV services that target the general public (e.g., poster campaigns for display on public transit, TV or radio public service announcements, etc.);
- Broad scope awareness activities about HIV services that target the general public;
- Outreach activities that have HIV prevention education as their exclusive purpose;
- Influencing or attempting to influence members of Congress and other federal personnel;
or
- Foreign travel.

1.74 Business Management

Successful respondents are required to ensure that the following items are in place:

- Documented policies and procedures and fiscal and programmatic reports that provide effective control over and accountability for all funds in accordance with federal and Ryan White programmatic requirements;
- Demonstrated structured and ongoing efforts to avoid fraud, waste, and abuse (mismanagement) in any federally funded program;

- Corporate Compliance Plan (required by the U.S. Centers for Medicare & Medicaid Services if providing Medicare or Medicaid reimbursable services);
- Personnel policies;
- Code of Ethics or Standards of Conduct;
- Bylaws and board of directors policies;
- File documentation of any employee or board member violation of the Code of Ethics or Standards of Conduct;
- Documentation of any complaint of violation of the Code of Ethics or Standards of Conduct and its resolution;
- Documentation of provider bylaws, Board of Directors Code of Ethics, and business conduct practices;
- Documentation of adequate policies and procedures to discourage soliciting cash or in-kind payments for:
 - Awarding contracts;
 - Referring clients;
 - Purchasing goods or services; or
 - Submitting fraudulent billings.
- Documentation of employee policies that discourage:
 - Hiring of persons with a criminal record;
 - Hiring of persons being investigated by Medicare or Medicaid; and
 - Large signing bonuses.

1.8 Meeting Requirements

- Respondents who receive funding under this RPS are required to participate in quarterly fiscal site visits and annual quality assurance and quality management site visits (audits) conducted by the RWSP.
- ***Attendance is required at Ryan White Planning Council monthly meetings.*** Meetings take place the first Thursday of each month. HHC/MCPHD shall make every effort to notify subcontractors of each required meeting at least fourteen days prior to such meeting. Attending representative does not have to be a member of the Planning Council.
- ***Attendance is required at Quarterly Provider Meetings.*** Dates will be included in the scope of work included in contracts for 2020-2021.
- Successful respondents shall make key staff (those responsible for implementation of the agreement) available for administrative meetings, conferences, and trainings as determined appropriate and mandatory by HHC/MCPHD at no expense to HHC/MCPHD.

1.9 Drug Free Workplace and HIPAA Compliance

Respondents must adhere to a drug free workplace policy. Respondents must also institute and adhere to Health Insurance Portability and Accountability Act of 1996 (HIPAA) policies, procedures and requirements in the delivery of service provisions agreed to under this request. See <https://www.hhs.gov/hipaa/>.

1.10 Proposal Clarifications and Discussions and Contract Discussions

- HHC reserves the right to request clarifications on proposals submitted in response to this request. HHC also reserves the right to conduct personal discussions, either oral or written, with respondents.
- HHC/MCPHD may require successful respondents to participate in negotiations and to submit revisions to pricing, technical information, or other items from their proposal(s).
- Site visits may be conducted to verify information submitted in the proposal or to determine if proposed facilities are appropriate for the proposed service.

1.11 Payer of Last Resort

Services funded through the Ryan White Part A/MAI Program that are billable to a third-party payer must be reimbursed by such payers and should be determined before Ryan White funds are used to pay for care, making Ryan White funding the “payer of last resort.” Ryan White funding may pay for services that fill the gaps in coverage of these other private or public health care programs; however, Ryan White funds cannot be used to balance a bill for services that should be reimbursed or paid by other payers.

1.12 Program Income

- Program income is gross income earned by the recipient that is directly generated by a supported activity or earned as a result of the award (see exclusions in 45 C.F.R. part 74.24, subdivisions (e) and (h)). Program income includes, but is not limited to, income from fees for services performed, collection of client co-pays, the use or rental of real or personal property acquired under federally-funded projects, and interest on loans made with award funds. The Ryan White legislation states that income resulting from fees for services performed (e.g., direct payment or reimbursements from Medicare and third party insurance) can be considered program income. [45 C.F.R. part 74.2]
- All program income is to be used by the respondent to provide Ryan White-eligible services to Ryan White-eligible clients and to be tracked and reported to HHC/MCPHD.

1.13 Financial Management

Respondents, if funded, are required to provide the RWSP access to:

- Accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports, and all other financial activity reports of the respondent;

- All financial policies and procedures, including billing and collection policies and purchasing and procurement policies; and
- Accounts payable systems and policies.

Respondents, if funded, are required to ensure adequacy of agency fiscal systems to generate needed budgets and expenditure reports. Respondents, if funded, are required to document all requests for and approvals of budget revisions.

1.14 Supplanting of Ryan White Program Funds

Ryan White Program funds cannot be used to supplant (replace or substitute) other federal, state, or other funds in the payment of services for clients.

1.15 Confidential Information

Respondents are advised that materials contained in proposals are subject to the Access to Public Records Act (APRA), IC 5-14-3 *et seq.* and, after the contract award, the proposal may be viewed and copied by any member of the public, including news agencies and competitors. Respondents claiming a statutory exception to the APRA must place confidential documents (including the requisite number of copies) in a sealed envelope clearly marked “Confidential” and must indicate in the Transmittal Letter and on the outside of that envelope that confidential materials are included. The respondent must also specify which statutory exception of the APRA applies. HHC/MCPHD reserves the right to make determinations of confidentiality. Agency fee schedule prices are not confidential information.

1.16 Client Documentation

Respondents must maintain documentation of all client interactions and services provided. Acceptable forms of documentation include electronic or paper medical records, either of which is subject to review and audit by HHC/MCPHD or its designated agent. Documentation should include: verification of client eligibility for services, dates of service, number of units of services provided to the client and billed to the RWSP, case notes that summarize the reasons the client was seeking assistance, the intervention or action that was provided, documentation of appropriate referrals (as applicable), the outcome of the intervention, and an updated care or treatment plan.

1.17 Information Security

Computer systems containing client information must be protected with multiple passwords. Office equipment used for storing confidential materials must be locked when not in use. Respondents must adopt and adhere to written policies and procedures that specify that client information is considered confidential, privileged information. The respondent must possess a written policy that limits access to client records to only the client, the agency’s HIV staff, the HIV program management personnel, and other monitoring or reimbursement agencies with a legitimate need to know. Release of information to entities other than those noted herein must be preceded by a written consent form that the client or client’s legal representative has signed, except as demanded under state statutes. These policies and procedures must include provisions for discipline should a violation occur. Information security is subject to review at site visits.

1.18 Referrals

The Service Referral Process as defined below will be considered to be a condition of award for all funded providers for 2020-2021.

- All services, either internal or external, require a documented referral for a referred service delivery to be considered reimbursable by the RWSP.
 - The referring provider will complete the Ryan White HIV Services Program Core and Support Services Referral Form. The completed Referral Form will be sent directly to the sub-recipient/provider that will deliver the service. Forms should be securely faxed or emailed to the provider. The sub-recipient/provider who delivers a Ryan White service to a client is responsible for ensuring the client is eligible and enrolled in the Ryan White/HIV Services Program. In addition to the Referral Form a Plan of Care should also be sent to the provider. Exceptions to this are Referrals to Substance Abuse-Residential Services, and requests for medications from Walgreens. These will be sent to RWSP.
 - Internal Agency Referrals: Internal agency referrals are for services provided in or by the referring entity. For example, an agency is funded to provide mental health services and non-medical case management. The non-medical Case Manager can directly refer a client to mental health services in that agency. However, it is expected that an internal referral form will be completed and included in the client's record. The guidelines below apply to all referrals, either internal or external, but not to the referral-exempt services noted earlier.
 - The referring agency or person must document a determination of need for the service being requested.
 - Agencies or programs to which the referral is being made must establish a plan of care for that service and client and document progress on related goals and objectives reportable on the six-month and year-end progress reports.
 - The Plan of Care and progress reports must be shared with the referring agency, internal program, or individual on at least a monthly basis.

1.19 Americans with Disabilities Act

Respondents agree to comply with provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et seq.*, and 47 U.S.C. 225).

1.20 Types and Term of Contract

HHC/MCPHD intends to sign a contract with one or more respondents to fulfill the requirements in this request. The initial term of the contract to be awarded is for a 12-month period which shall commence March 1, 2019 and continue through February 29, 2020. Funding and services provided during one additional 12-month period are conditioned upon the successful completion and submission to HHC of annual progress reports detailing goals and objectives and fiscal utilization of funds. Additionally, agencies will have the opportunity to add or delete services, based on demonstrated need, in year three of the contract period, upon approval of the RWSP.

Respondents are required to adhere to all elements in the contract and must agree to do so in writing.

1.21 Due Date for Proposals

Proposals must be submitted on 8½-inch by 11-inch paper, single-sided and neatly typed, with 1-inch margins. An unbound, one-sided original and four unbound copies (five in total) of the complete proposal must be received by **12:00 PM (Noon) January 28, 2020**.

All proposals must be mailed or hand delivered to:

Ryan White HIV Services Program
Attention: Michael Butler, Director
Marion County Public Health Department
2951 East 38th St., Suite 203
Indianapolis, IN 46218

Proposals received after the due date and time will not be considered eligible for funding.

Section 2.0: Scope of Services and Program Requirements

2.1 Scope of Services Requested

The service categories available for funding under this request for fiscal year 2020-2021 are listed in Section 7.0: Services Eligible for Funding 2020-2021. Each service category contains a description of service(s) to be provided and the anticipated amount available for funding in each category. Level of funding in each category is contingent on the amount of the grant award received by the MCPHD. Respondents are permitted to seek funding for one or more of the listed categories; however, respondents must identify their ability to implement and monitor each service, both programmatically and fiscally. Successful respondents will address each service category separately, including separate goals, objectives, budget, and the means by which to make the service equally available to any enrolled client within the TGA.

2.2 Minority AIDS Initiative (MAI) Requirements

- Ryan White Part A/MAI funds are designated to reduce HIV-related health disparities and improve health outcomes for HIV-positive minorities, specifically African Americans and Hispanics.
- MAI funds for this RPS will be available to support Health Education and Risk Reduction, Mental Health Services, Early Intervention Services (EIS), Non-Medical Case Management, and Outpatient/Ambulatory Health Services.
- Per Federal requirements, agencies funded to provide MAI services must meet the following criteria:
 - Clearly specified target population(s) to be served (and, if more than one racial or ethnic group is targeted, the percentage that each group will represent of the total number of clients to be served);
 - Location in or near to the targeted communities that the respondents are intending to serve;
 - Documented history of providing services to the targeted communities;

- Documented linkages to the targeted populations designed to help close gaps in access to services for highly impacted communities of color;
- Documented history of providing services in a manner that is culturally and linguistically appropriate; and
- Ability to account for MAI funds separately.

2.4 Program Requirements

All Ryan White funded programs, in any service category, must:

- Meet a clearly defined unmet need, target population, or geographic area based upon the service priorities established by the Indianapolis TGA Ryan White Planning Council;
- Ensure mechanisms for ongoing monitoring for quality and program evaluation;
- Establish mechanisms to ensure that clients who receive Ryan White Program funded services are not eligible for services funded by other sources, including mechanisms to document that all other service options to meet a client's need were explored and a determination was made that no other resource was available before RWSP funds are used;
- Have a process for coordination with existing HIV service providers, as appropriate, and participate in an HIV/AIDS community-based continuum of HIV prevention and care;
- Ensure mechanisms are in place to increase access to care for eligible clients in the TGA;
- Have a process to facilitate culturally and linguistically appropriate service delivery, as needed, at any time during the contract period;
- Establish mechanisms for outreach to individuals with HIV/AIDS who may be *aware of their status*, but who are not in care, make these individuals aware of available services, and assist in bringing those eligible for services into care;
- Establish mechanisms and specific strategies to identify individuals who are *unaware of their HIV status*, make them aware, and assist in bringing them into care;
- Explain how your agency will develop and maintain program enrollment policies, which shall be in writing and available to the public; and
- Explain how the respondents will assist and support the development of the Ryan White Part A/MAI Program.

Section 3.0: Proposal Format

3.1 General

The proposal must be divided into the sections as described below, beginning with Section 3.2. The same outline numbers must be used in the response. The response must be in a narrative format on 8.5 x 11 inch paper, in a 12-point font. Respondents must also adhere to the additional guidelines below.

- Margins must be one-inch on all sides of the page.
- All attachments should be clearly labeled in the Table of Contents.
- Proposals should not exceed 25 pages. Only the following sections are included in this page limit: Abstract (section 3.5), Respondent Agency Administration (section 3.6), Proposed Services (section 3.7), Client Eligibility Criteria (section 3.8), and Quality Management (section 3.9). Attachments, including the budget and budget justification, are not included in the page limit.

3.2 Cover Letter

The cover letter must address items below.

- **Agreement with requirements as outlined in the RPS:** Respondents must explicitly acknowledge understanding of the information presented in the RPS and express agreement with all requirements and conditions listed, including fiscal management, reporting requirements, National Monitoring Standards, and Indianapolis TGA Standards.
- **Summary of abilities and desire to supply the required products or services:** Respondents must briefly summarize their ability to supply the requested services and to meet the requirements defined in this RPS.
- The cover letter must contain a statement indicating the respondent's willingness to provide the requested services subject to the terms and conditions set forth in the RPS including, but not limited to, the HHC/MCPHD mandatory contract clauses.
- The cover letter must contain a statement indicating the respondent's **obligation and agreement** to provide the requested service(s), if funded, to any eligible and enrolled client anywhere within the Indianapolis TGA (Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam, and Shelby Counties).

The cover letter must clearly state under which funding category (-ies) the respondent is seeking funding: Part A, MAI, or both.

- Respondents must clearly **demonstrate their ability** to provide the service(s) to any eligible and enrolled client within the TGA before consideration of funding will be given.
- The cover letter must include: date, applicant agency name and complete address (including zip code), and applicant agency telephone and fax numbers.
- The cover letter must include separately the following names, signatures, and e-mail addresses:
 - Program Contact;
 - Authorized Contact (the person authorized to commit the respondent to its representations and who can certify that the information offered in the proposal meets all general conditions in the RPS); and
 - Applicant contact.

3.3 Requested Service Form

Respondents must include the following items on the Requested Service Form (*Attachment B*):

- The services to be provided (one service per form) and the amount of funds requested per service; and
- The original signature of the individual who is legally authorized to enter into a contractual relationship in the name of the respondent agency.

An example of a completed Requested Service Form is included in the Attachment Section of this RPS.

3.4 Table of Contents

- The Table of Contents should outline in sequential order the major areas of the proposal.
- All pages of the proposal, including the attachments, must be clearly and consecutively numbered and reflected accurately in the Table of Contents.
- Attachments can be numbered distinctly from the narrative; however, each page should be numbered sequentially.

3.5 Abstract for the Proposed Funding Request (limited to two pages)

The abstract must include:

- Full, legal name of the proposing agency;
- Corporate or tax status of the proposing agency (e.g., non-profit);
- Brief description of the identified service needs and demands and target population and primary geographic area;
- Number of clients to be served;
- Number of units of service to be provided;
- Brief description of the proposed program and service approach; and
- Total budget request.

3.6 Respondent Agency Administration

Each of the sections below must be addressed.

- **Staffing:** Describe the Respondent's current HIV program staff and experience in delivering services to the identified population. All funded respondents must maintain and make available to the RWSP copies of valid licenses, certifications, and registrations of health and supportive service professionals documenting qualifications to provide the specified service(s). *Please do not include resumes.*

- **Hours of Operation:**
 - Describe the respondent's hours of operation (for each location, if applicable).
 - Describe how the dates and times are made known to clients.
 - Describe the means by which services are promoted and made known to clients, to other agencies serving the population, and to the entire TGA. Special consideration will be given to respondents who demonstrate diversity in hours of service provision and delivery.

- **Continuous Quality Improvement:**
 - Describe the respondent's capacity to ensure continuous quality improvement. *Continuous quality improvement is an ongoing process of monitoring and evaluating activities and outcomes with the objective of continuously improving service delivery.* Continuous quality improvement seeks to identify or prevent problems and maximize access, utilization, and quality of care.
 - Describe the orientation process for new staff to ensure they are knowledgeable about the program, enrollment, certification, recertification, cultural competency, referral processes, and billing.
 - Describe the respondent's plan for ongoing training to ensure that staff maintains current knowledge about HIV disease, services, treatments, referral processes, cultural competency, and other relevant information.

- **Service Experience:**
 - Describe the agency's unique capacity and qualifications to deliver the requested services.
 - Describe the agency's cultural and linguistic capabilities. Agencies who receive funding under this proposal **MUST** demonstrate the ability to provide the funded services to any enrolled RWSP client within the Indianapolis TGA. ***Failure to provide a plan that demonstrates this ability will severely impact the viability of the respondent's application.***

- **Intake:**
 - Describe the agency's client orientation process.
 - Describe the agency's intake process for enrollment, including provision of information on agency services, programs funded by the RWSP, and other programs in the community at large that provide services to the identified populations(s).

- **Client Confidentiality:** Explain the agency's system for safeguarding the confidentiality of clients, including:
 - The agency's definition of confidentiality;
 - Policies regarding staff compliance with confidentiality regulations, including how a breach of confidentiality would be handled;
 - The agency's efforts to conduct regular training on confidentiality issues;
 - Protection of client records;

- Exchange and release of information;
 - The staff person who conducts your confidentiality training;
 - Protection of client privacy; and
 - The agency's actions to comply with HIPAA rules and regulations. Note: All agencies funded by the RWSP must comply with HIPAA rules, regulations, and standards.
- **Consumer Involvement:** Describe how the agency solicits input from people living with HIV in its decision making process. If your agency conducts patient or client satisfaction surveys, attach a copy of the most recent survey results, along with a summary of the actions (if any) taken in response. If your agency has a consumer advisory board, describe the board membership and processes by which the board operates.
- **Special Populations and Geographic Accessibility:** Explain how the agency will serve clients of all geographic areas of the Indianapolis TGA. Respondents must demonstrate the ability to do so in keeping with the cultural and ethnic sensitivities of the population(s) to be served.
- **Data Collection and Reporting:**
 - Describe the agency's system for collecting, maintaining, and reporting client level service delivery data.
 - Explain who is responsible for collecting and entering data, generating reports, and conducting quality assurance activities.
 - All service data for which payment is being sought must be entered into CAREWare (unless another data collection and reporting system is approved) accurately and completely by the 20th day of the month after the month of service delivery or payment will be delayed. **Please note:** Unless otherwise specified and approved prior to funding by the RWSP, CAREWare is the data collection and reporting software mandated for all agencies funded under this guidance. Submission of client level data is a mandate of the Health Resources Services Administration (HRSA) and a requirement for funding consideration and continuation. Respondents without the ability to supply the data in the requested format or who cannot provide the data to HHC/MCPHD in a timely manner will not be considered for funding. Detailed information regarding HRSA required data collection and reporting may be found here: <https://hab.hrsa.gov/program-grants-management/ryan-white-hiv-aids-program-services-report-rsr>
 - Successful respondents must submit semi-annual progress reports to the RWSP. The format for these reports will be provided and will consist of programmatic and financial content. Agencies will be expected to submit a year-end report within 30 days after the grant period ends.

- **Fiscal Staff Accountability:** Describe the following:
 - The process that will be used to monitor Part A/MAI program expenditures and the strategy used to ensure that expenditures are timely and sufficient to be maintained throughout the grant year (including the person(s) responsible for this process, which fiscal reports are generated, and how often are they generated);
 - The process and person(s) responsible for ensuring that services funded by Part A/MAI and Part B are tracked separately, and services/job functions are billed to only one funding source;
 - The process and person(s) responsible for submitting vouchers for payment to the RWSP;
 - The process used to ensure that billing for services is in compliance with the RWSP contract; and
 - The process and documentation of ensuring that clients have been screened for and (if eligible) enrolled in all applicable programs, including Medicaid, State Children’s Health Insurance Program (SCHIP), Medicare (including the Part D prescription drug benefit), and private insurance in order to coordinate benefits and to document that the RWSP is the payer of last resort.
 - The respondent must delineate the process by which the cost per unit of service is determined and how they will track the elements contained in this cost per unit. This information will need to be available at the time of the RWSP quarterly fiscal and annual monitoring.

3.7 Proposed Services

Please refer to Section 7.0 while responding to the following questions. Section 7.0 (Services Eligible for Funding 2020-2021) contains the HRSA definitions for core and supportive services.

- Describe each service for which funding is requested and explain how that service will be delivered. Explain the underlying rationale for your proposed service approach.
- Describe the target population to be served by the proposed services. Explain how your agency will reach the target population and increase their access to services.
- Explain how Part A/MAI services will be integrated with other services your agency provides and with those provided by other agencies in the community. Describe how your agency will coordinate and document services with other community agencies, including referral and follow-up mechanisms.
- Explain how this service coordination supports the TGA’s continuum of care, brings clients into care, maintains clients in care, assists with identifying individuals who are unaware of their HIV status, and reduces duplication of services.
- For those persons who may be unaware of their HIV status, describe the specific strategies your agency will use to identify these individuals, offer (or refer to) HIV counseling and testing, and (if HIV-positive) ensure these individuals access care.

- Describe your agency’s intake process. Explain how your agency manages “walk-ins,” especially for individuals in crisis, and include an explanation of how your agency monitors the availability of slots for specific services.
- Describe your agency’s process for handling “inactive” clients. Explain how “inactive” is defined and how you ensure these individuals are not lost to care. Describe the mechanisms in place to track this information.
- For each requested service, please complete and attach one *Attachment B: Requested Service Form*.
- If your agency is proposing to provide **early intervention services (EIS)**:
 - Describe how your agency will successfully target high-risk populations in underserved areas with a high prevalence of HIV disease.
 - Describe the tools or strategies your agency will use to identify geographical areas that have high prevalence of HIV disease.
 - Describe the type(s) of HIV test(s) that will be used.
 - Describe the hours that EIS services will be conducted (acknowledging that special consideration will be given for agencies that will conduct EIS during “non-traditional” hours).
 - Describe your post-test counseling process for clients who have a positive confirmatory HIV test.
 - Describe your process for handling clients who have a positive confirmatory HIV test, but do not return for final test results.
 - Describe how your agency will link clients who have a positive confirmatory HIV test into HIV care.
 - Describe your agency’s process for following up with the HIV-positive client after the referral or linkage to care has occurred.
- If your agency is proposing to provide MAI-funded services:
 - Identify by service category (e.g.; Mental Health Services, Outpatient/ Ambulatory Health Services, or HE/RR) which MAI population(s) your agency proposes to serve.
 - Describe how your agency will successfully target the identified minority population(s).
 - Describe how your proposed services will improve HIV – related health outcomes, and reduce existing racial and ethnic health disparities.
 - Describe how these activities address the unique needs of the targeted MAI population(s).

3.8 Client Eligibility Criteria

Describe your agency’s process to ensure that clients who receive Ryan White Part A/MAI services are actively enrolled in the HHC/MCPHD RWSP and re-certified every six months. All determinations of eligibility must be documented in a manner that is satisfactory to HHC/MCPHD and the RWSP. Failure to adequately document such eligibility may, at

HHC/MCPHD's sole discretion, result in non-payment to the funded respondent for services furnished to non-enrolled clients. Eligibility and enrollment are determined by:

- Documentation of a positive confirmatory HIV test;
- Documented income that does not exceed 300% of the Federal Poverty Level;
- Documentation that the client is a resident of the Indianapolis TGA; and
- Documentation that the client has been properly screened for insurance eligibility, State AIDS Drug Assistance Program (ADAP), Medicaid, Medicaid Waiver, and other public sector funding as appropriate. If clients qualify for and can access other sources of benefits (including entitlement programs), they are not eligible for Ryan White Part A/MAI funds, except for those services, tests, and procedures not covered by such other funding sources.

3.9 Quality Management Program

The Ryan White HIV/AIDS Modernization Act requires that all Part A Grantees and subcontractors “provide for the establishment of a (CQM) [Clinical Quality Management] program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent PHS guidelines for the treatment of HIV/AIDS and related opportunistic infection and, as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.”

Quality Management (QM) data plays a critical role in documenting that services delivered to clients are improving their health status. Information gathered through the QM program, as well as client-level health outcomes data, should be used to guide program planning and ongoing assessment of progress toward achieving the goals and objectives outlined in the Part A QM plan, which can be found here:

http://www.ryanwhiteindynga.org/File/Clinical_Quality_Management_Plan.pdf and agency-specific goals and objectives. It should also be used by the sub-recipient to examine and refine services based on outcomes and the cost of delivering quality care.

By submission of an application under this RPS, respondents commit to the development of a Quality Management Plan to be submitted to the RWSP by May 15, 2019. Information about quality management can be found on the National Quality Center web site:

<http://nationalqualitycenter.org/quality-improvement-resources/quality-expectations-for-ryan-white-grantees/>. The RWSP will provide a template for QM Plans once contracts have been executed. Additional information about your agency quality management processes and activities may be requested once contracts have been executed.

For reference, the national HRSA/HAB performance measures can be found at:

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

Section 4.0: Budget and Budget Justification

HHC uses cost reimbursement as a basis for payment of expenditures incurred by successful respondents. A budget for the grant period must be submitted for approval. Reimbursement invoices for incurred budgeted expenses must be submitted on a monthly basis. Respondents must determine and indicate the cost of providing a proposed service to each client on a fee for services basis and demonstrate the ability to monitor the cost per unit of service on an ongoing basis. Funding is not available to cover the cost of supporting full time equivalent (FTE) staff, unless exclusively dedicated to providing services to only enrolled clients of the RWSP.

4.1 Summary Budget Request

Respondents must complete *Attachment C* which includes the Summary Budget Request and must clearly identify if the Request is for Part A or MAI. A separate Summary Budget Request must be completed for Part A funding and MAI funding.

4.2 Line Item Budget Request

- Respondents must complete *Attachment C* which includes the Line Item Budget Request. A separate Line Item Budget Request must be completed for Part A funding and MAI funding.
- Respondents must prepare a narrative Line Item Budget Justification, to be attached to the application immediately following the Line Item Budget Request. A justification for each proposed service must be provided. The determination of cost should be done using a cost-based (fee for services) reimbursement methodology. A separate Line Item Budget Justification must be completed for Part A funding and MAI funding.

4.3 Formula for Costs

Respondents must include the formula by which they derived their cost per unit of service. This formula must be attached the application immediately following the narrative Line Item Budget Justification. The formula response must describe the unit of service to be delivered, the number of anticipated units to be delivered to an individual client, the cost per unit of service, and the anticipated cost per client. Cost per unit of service is determined by adding all direct costs related to the service and then dividing this sum by the number of anticipated encounters. Direct allowable expenses include annual personnel salary, fringe benefits, supplies, etc., necessary for the delivery of the requested service. Overall administration of the program or the grant award is not to be included in this formula, nor is staff training expense. The respondent must keep in mind the unit fee must be reasonable, include allowable cost, be reconciled annually to assure the sub-recipient does not exceed its cost by billing unnecessary units, and must assure the administrative cost does not exceed the allowable 10 percent. Finally, the sub-recipient contracts must have a budget that reflects the cost of the service rate/fee, a well-defined unit, and end-of-year reconciliations to ensure the unit costs are allowable and reasonable.

NOTE: There are exceptions to the establishment of a formula for costs per unit of service:

- Outpatient Ambulatory; 2) Primary Medical, and 3) Oral Health Services. These services will be reimbursed based on current, accepted, and accredited CPT codes and according to “usual and customary” negotiated reimbursement rates.

- Services that do not require a cost per unit of service determination are services that are paid by actual cost: Emergency housing, emergency utilities, emergency food, emergency pharmacy, local pharmacy assistance, medical transportation (bus tickets or vouchers), home delivered meals, and legal services.

4.4 Administrative Costs

Administrative costs are to be shown on the Line Item Budget Request form and explained in the Justification Narrative. The respondent is permitted to request up to 10% of the total requested amount to support the cost of administration. Allowable administrative expenses must be directly related to Ryan White Part A/MAI services and must be reasonable. Actual administrative expenses are reportable at the end of the grant year. Respondents are reminded that if any administrative costs are included in the cost per unit of service formula that cost will count toward their total allocated administrative costs.

4.5 Respondent Agency Financial Documents

Respondents are required to attach specific financial documents to their applications.

- Attach a financial statement for your agency, including an income statement and balance sheet for each of the two most recently completed fiscal years. The financial statements must demonstrate the respondent agency's financial stability.
- Attach the agency's most current, complete, certified audit verifying that the agency is financially sound and able to implement a funded service on a reimbursement basis. Financial statements do not represent a complete audit. Therefore, if a certified audit is not available, financial statements and detailed plans to comply with contractual audit requirements must be submitted as part of the proposal narrative.

Section 5.0: Reimbursement Submissions

Funded respondents shall submit invoices and associated documentation by the 20th of each month (reporting for the previous month). Appropriate documentation shall accompany each invoice and consists of: invoices and receipts (or cancelled checks) from vendors for any supplies, incentives, rentals, or equipment; proof of payment to vendors for supplies or equipment; fully completed and certified HHC/MCPHD outreach logs; certified statements attesting to all administrative work performed pursuant to the Agreement; and, certified statements detailing the attendance and purpose of meetings and training sessions. Failure to submit invoices with appropriate documentation or to complete data entry for service provision submitted for reimbursement (into CAREWare or other approved software) will result in payment delays from the RWSP.

5.1 Re-allocation of Funding

Funded respondents shall use funds in a timely manner. The RWSP Director reserves the right to re-allocate funds based on sub-contractors' demonstrated ability to utilize funds. If funds are not expended at a rate of at least 25% of the contract amount per quarter of the grant year, the Program Director may begin the reallocation process.

5.2 Delinquency

Failure to submit timely reimbursement requests without consultation and approval from the RWSP will constitute delinquency and awarded funds will be subject to reallocation. If funds are not utilized in a timely manner, RWSP staff will request that the Ryan White Planning Council reallocate unused or anticipated unused dollars to other Ryan White service categories or funded providers. Contracts with the affected agencies will be amended to reflect the change in fiscal responsibilities. The RWSP Director reserves the right to de-obligate allocated funding to a specific subcontractor and re-obligate funds to other subcontractors if expenditures are not made at a rate of at least 25% of the contract amount per quarter of the grant year.

Section 6.0: Evaluation of Proposals

Proposals will be evaluated using an objective external/internal review process. A team of community representatives, consumers, and health professionals will review proposals and make recommendations for funding. Individual applications are not compared to other applications; rather, each is evaluated independently in terms of responsiveness to the RPS.

Section 7.0: Services Eligible for Funding 2020-2021

Each of the following service categories has corresponding requirements in both the National Monitoring Standards and the Indianapolis TGA Standards of Care. Respondents must comply with all requirements for each service for which funding is requested. Please refer to the earlier discussion of the National Monitoring Standards and the Indianapolis TGA Standards of Care in Section 1.6: Eligibility for Consideration of Funding.

Also please see <http://hab.hrsa.gov/manageyourgrant/granteebasics.html> for the National Monitoring Standards and <http://dev.ryanwhiteindynga.org/File/Indianapolis-TGA-Standards-of-Care.pdf> for the Indianapolis TGA Standards of Care. National and local standards may also be obtained by contacting the RWSP directly. Likewise, if you require assistance in interpreting these standards documents, please contact the RWSP.

7.1: Core Service Categories

- **AIDS Pharmaceutical Assistance (Medicaid Billing Eligible)**

Local Pharmaceutical Assistance Program (LPAP) is a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.

-Recommended Part A funding allocation: \$49,000

- **Early Intervention Services (EIS) (Not Medicaid Billing Eligible)**

EIS must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected;
 - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts.
 - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources.

- Referral services to improve HIV care and treatment services at key points of entry;
- Access and linkage to HIV care and treatment services, such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care; and
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

Successful respondents must monitor and report on the number of individuals tested, number of tests conducted, and the number of confirmed HIV positive individuals found during the grant year.

-Recommended Part A funding allocation: \$576,000

-Recommended Part MAI funding allocation: \$103,276

- **Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (Not Medicaid Billing Eligible)**

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and /or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client (deductibles).

Part A funding is used to supplement, not supplant, existing federal, state, or local funding for Health Insurance Premium and Cost Sharing Assistance.

-Recommended Part A funding allocation: \$20,000

- **Medical Case Management, Including Treatment Adherence Services (Not Medicaid Billing Eligible)**

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Medical Case Management may include the following:

- Initial assessment of service needs;
- Development of a comprehensive, individualized care plan;
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care;
- Continuous client monitoring to assess the efficacy of the care plan;

- Re-evaluation of the care plan at least every 6 months with adaptations as necessary;
- Ongoing assessment of the client's and other key family members' needs and personal support systems;
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; and
- Client-specific advocacy and/or review of utilization of services.

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

-Recommended Part A funding allocation: \$1,201,200

- **Medical Nutrition Therapy (Not Medicaid Billing Eligible)**

Medical Nutrition Therapy includes:

- Nutrition assessment and screening;
- Dietary/nutritional evaluation;
- Food and/or nutritional supplements per medical provider's recommendation; and
- Nutrition education and/or counseling.

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services. All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional.

-Recommended Part A funding allocation: \$85,000

- **Mental Health Services (Medicaid Billing Eligible)**

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers. Mental Health Services are allowable only for HIV-infected clients.

-Recommended Part A funding allocation: \$6,000

-Recommended MAI funding allocation: \$3,200

- **Oral Health Care (Medicaid Billing Eligible)**

Oral Health Care services include diagnostic, preventive, and therapeutic dental care that is in compliance with state dental practice laws, include evidence-based clinical decisions that are informed by the American Dental Association Dental Practice

Parameters, are based on an oral health treatment plan, and are provided by licensed and certified dental professionals.

-Recommended Part A funding allocation Part A: \$61,200

- **Outpatient/Ambulatory Health Services (Medicaid Billing Eligible)**

Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking;
- Physical examination;
- Diagnostic testing, including laboratory testing;
- Treatment and management of physical and behavioral health conditions;
- Behavioral risk assessment, subsequent counseling, and referral;
- Preventive care and screening;
- Pediatric developmental assessment;
- Prescription, and management of medication therapy;
- Treatment adherence;
- Education and counseling on health and prevention issues; and
- Referral to and provision of specialty care related to HIV diagnosis.

-Recommended Part A funding allocation: \$427,380

-Recommended MAI funding allocation: \$79,019

- **Outreach Services**

Outreach services include the provision of the following three activities:

- Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services;
- Provision of additional information and education on health care coverage options; and
- Reengagement of people who know their status into Outpatient/Ambulatory Health Services.

-Recommended Part A funding allocation: \$34,051

- **Substance Abuse Outpatient Care (Medicaid Billing Eligible)**

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening;
- Assessment;
- Diagnosis, and/or;
- Treatment of substance use disorder, including:
 - Pretreatment/recovery readiness programs;
 - Harm reduction;
 - Behavioral health counseling associated with substance use disorder;
 - Outpatient drug-free treatment and counseling;
 - Medication assisted therapy;

- Neuro-psychiatric pharmaceuticals; and
- Relapse prevention.

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan. Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA or HAB-specific guidance.

-Recommended Part A funding allocation: \$35,000

7.2: Support Service Categories

- **Emergency Financial Assistance (EFA) – Food, Utilities (Not Medicaid Billing Eligible) Pharmacy (Medicaid Billing Eligible), Housing (Not Medicaid Billing Eligible)**

This is the short-term provision of programs to assist with emergency expenses related to essential food, utilities, pharmacy, and housing. This service is provided to clients with limited frequency and limited periods of time, through either one-time or short-term payments to agencies, or establishment of voucher programs. Direct payments to clients are not permitted. It is anticipated that clients would only utilize one unit of service within a grant year. The successful respondent will demonstrate that all avenues for alternate payment have been exhausted before allocation of Ryan White funding for this service category (maintaining the program as the payer of last resort). The sub-recipient must record, track use of, and reconcile EFA funds separately under each discrete service category (i.e., food, utilities, pharmacy, or housing) as required by the RWSP.

-Recommended Part A funding allocations: Utilities \$50,000; Food \$36,400; Pharmacy \$45,045; Housing \$90,041

- **Health Education/Risk Reduction (Not Medicaid Billing Eligible)**

Health Education/Risk Reduction is the provision of education to targeted minority population clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status.

Topics covered may include:

- Education on risk reduction strategies to reduce transmission, such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention;
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage);
- Health literacy; and
- Treatment adherence education

Health Education/Risk Reduction services cannot be delivered anonymously.

-Recommended Part A funding allocation: \$120,000

- **Other Professional Services: Legal Services (Not Medicaid Billing Eligible)**

Funding is available for legal services provided to HIV-infected individuals to address legal matters directly necessitated by their HIV status. Legal services must be

rendered by individuals appropriately licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Assistance with public benefits such as Social Security Disability Insurance (SSDI);
- Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP;
- Preparation of healthcare power of attorney, durable powers of attorney, and living wills;
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
 - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney;
 - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption; and
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWSP.

-Recommended Part A funding allocation: \$10,000

- **Linguistic Services (Not Medicaid Billing Eligible)**

Linguistic Services provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWSP eligible services.

Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

-Recommended Part A funding allocation: \$20,020

- **Medical Transportation (Medicaid Billing Eligible)**

Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services. Medical transportation may be provided through:

- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject);
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle;

- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed);
- Voucher or token systems Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.
- Unallowable costs include:
 - Direct cash payments or cash reimbursements to clients;
 - Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle; and
 - Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

-Recommended Part A funding allocation: \$70,000

- **Non-Medical Case Management Services (Not Medicaid Billing Eligible)**

Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case Management Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer’s Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWSP. Key activities include:

- Initial assessment of service needs;
- Development of a comprehensive, individualized care plan;
- Continuous client monitoring to assess the efficacy of the care plan;
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary; and
- Ongoing assessment of the client’s and other key family members’ needs and personal support systems.

Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management Services have as their objective improving health care outcomes.

-Recommended Part A funding allocation: \$700,260

-Recommended Part MAI funding allocation: \$76,890

- **Psychosocial Support Services**

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Caregiver/respice support (HRSA RWHAP Part D)
- Child abuse and neglect counseling

- HIV support groups
 - Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
 - Pastoral care/counseling services
- Recommended Part A funding allocation: \$34,050

- **Substance Abuse Services (Residential) (Medicaid Billing Eligible)**

Substance Abuse Services (Residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes:

- Pretreatment/recovery readiness programs;
- Harm reduction;
- Behavioral health counseling associated with substance use disorder;
- Medication assisted therapy;
- Neuro-psychiatric pharmaceuticals;
- Relapse prevention; and
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital).

-Recommended Part A funding allocation: \$35,520

Application Checklist

Please complete and submit as the first page of your application

- Cover Letter (see Section 3.2)
- Table of Contents (see Section 3.4)
- Abstract (see Section 3.5)
- Respondent Agency Administration (see Section 3.6)
- Proposed Services (see Section 3.7)
- Client Eligibility Criteria (see Section 3.8)
- Quality Management Program (see Section 3.9)
- Attachment A: E-Verify Affidavit and Contract Provision
- Attachment B: Requested Service Form(s)
- Attachment C: Budget and Budget Justification, including 1) Summary Budget Request; 2) Line Item Budget Request, with formula for cost per unit of service attached (See Section 4.3); and 3) Budget and Justification Narrative, which includes Formula for Costs
- Documentation of Non-Profit Status
- Documentation of Medicaid Certification (if applicable)

Attachment A

Contract Provision

Employment Eligibility Verification Required by Indiana Code § 22-5-1.7-11

Contractor affirms via the attached affidavit that Contractor does not knowingly employ an unauthorized alien and has enrolled and is participating in the E-Verify program. Contractor is not required to participate should the E-Verify program cease to exist. Contractor agrees to provide documentation demonstrating that Contractor has enrolled and is participating in the E-Verify Program. HHC may terminate for default if Contractor fails to cure a breach of this provision no later than thirty (30) days after being notified.

E-Verify Affidavit

**Affidavit
Employment Eligibility Verification
Required by Indiana Code § 22-5-1.7-11**

1. Contractor affirms that Contractor does not knowingly employ an unauthorized alien.

2. Contractor affirms under the penalties of perjury that it has enrolled and is participating in the E-Verify program. Contractor is not required to participate should the E-Verify program cease to exist.

3. Contractor agrees to provide documentation demonstrating that Contractor has enrolled and is participating in the E-Verify program.

4. HHC may terminate for default if Contractor fails to cure a breach of this provision no later than thirty (30) days after being notified.

I affirm, under the penalties for perjury, that the foregoing representations are true.

Contractor

Date

Attachment B: Requested Service Form Part A or MAI

(complete 1 form for each requested service and funding category)

Agency Name:

Authorized Contact and Title:

Signature of Authorized Contact:

Requested Service:	Amount Requested:	
Provide a <i>brief</i> description of the requested service and method of service delivery:		
Goal: Specify the overall result to be accomplished, i.e. what is the specific result being sought and why is it being sought:		
Objectives: Objectives are specific actions needed to reach your goal. Specify a single, measurable result for each objective. Objectives must be quantified and have a timeframe.	Define the service unit to be provided:	
	Number of people to be served:	Total number of service units to be provided:
Activities: Activities are strategies or tasks that must occur to implement each objective. Activities should include an action, identify who will do the action, identify materials and resources needed, and specify when the action will occur. Specify activities for each of your listed objectives.	Specify who will implement the activities and when the activities will be provided.	
Evaluation: Describe the specific method you will use to evaluate progress toward your goal and objectives: Who is responsible for evaluating the project and when during the grant year will evaluation be conducted? What actions will you take if you are not making progress toward your goal/objectives?	Specify who will evaluate progress toward goals and objectives. Use specific staff titles. Indicate when evaluations will be conducted and plans for corrective actions, if needed.	
Performance Measures: What measures will you use to evaluate your progress? How will these measures be created and monitored and by whom?	Specify which staff person will be responsible for collecting and reporting performance measures data. Indicate how often data will be collected and what system will be used to manage the data.	

Example

Attachment B: Requested Service Form Part A or MAI
(complete 1 form for each requested service and funding category)

Agency Name: Ryan White HIV Services Program

Authorized Contact and Title: Director

Signature of Authorized Contact: Matt Gutwein, CEO

Requested Service: Mental Health Services	Amount Requested: \$100,000	
Provide a <i>brief</i> description of the requested service and method of service delivery: The program is requesting funding to provide mental health services to Ryan White eligible and enrolled clients. The services will be delivered by licensed/professionals in the field of mental health and will be provided on a one on one basis.		
Goal: Specify the overall result to be accomplished, i.e. what is the specific result being sought and why is it being sought:		
1. To improve health outcomes of PLWH by providing access to and delivery of mental health services, including mental health counseling and access to psychiatric services and eliminate disparities in access to mental health services for disproportionately affected sub-populations and underserved communities.		
Objectives: Objectives are specific actions needed to reach your goal. Specify a single, measureable result for each objective. Objectives must be quantified and have a timeframe.	Define the service unit to be provided: A unit of service is defined as the provision of one hour of mental health services	
1. By 02/28/2019, provide 500 units of mental health services to 100 RW enrolled clients to improve health, and well-being of PLWH/A, assist in care retention and to decrease the impact of mental health issues on entry into care and to provide access to care for those who demonstrate a need for this service.	Number of people to be served	Total number of service units to be provided
	100	500
Activities: Activities are strategies or tasks that must occur to implement each objective. Activities should include an action and identify who will do the action. Specify activities for each of your listed objectives.	Specify who will implement the activities and when the activities will be provided.	
1. The completion of a treatment plan for the provision of mental health services. This plan will be made available to the referring agency, as will progress toward completion of the plan.	1. Agency and staff who are funded to do mental health services and the client for whom the plan is being developed. 2. Treatment plan will be completed within 7 working days of admission to program.	

<p>Evaluation: Describe the specific method you will use to evaluate progress toward your goal and objectives: Who is responsible for evaluating the project and when during the grant year will evaluation be conducted? What actions will you take if you are not making progress toward your goal/objectives?</p>	<p>Specify who will evaluate progress toward goals and objectives. Use specific staff titles. Indicate when evaluations will be conducted and plans for corrective actions, if needed.</p>
<p>Documentation of the referrals received, accompanying assessment, and the completion of a treatment plan if need for service is determined by the mental health staff.</p> <ol style="list-style-type: none"> 1. Upon acceptance to the mental health program, implementation, monitoring and reporting of treatment plan. 	<ol style="list-style-type: none"> 1. Funded mental health staff will conduct evaluations on a monthly basis. 2. If progress is not being met treatment plan team, including the client, will re-evaluate to determine what alterations, if any, are needed in the treatment plan
<p>Performance Measures: What measures will you use to evaluate your progress? How will these measures be created and monitored and by whom?</p>	<p>Specify which staff person will be responsible for collecting and reporting performance measures data. Indicate how often data will be collected and what system will be used to manage the data.</p>
<ol style="list-style-type: none"> 1. 75% of clients for whom a mental health treatment plan is completed will adhere to the treatment goals and objectives outlined in their mental health treatment plan. 2. 75% of clients who receive mental health services will remain “active” in the Ryan White HIV Services Program at the end of the grant year 	<p>Mental health service providers will document mental health treatment plan goals and objectives in case notes in CAREWare or other RWSP approved data management system. Client files will be randomly selected for quarterly review and reporting on the specified measures.</p>

Attachment C

- **Summary Budget Request**
 - **If applying for Part A and MAI complete a separate form for each**
 - **Provide detail about all funding sources**
 - **Provide detailed description of how you will track billing to other sources for services funded by Part A to prevent double billing**
- **Line Item Budget**
- **Budget and Justification Narrative (including Formula for Cost per Unit of Service)**
 - **Items included in cost per unit cannot be charged separately to administration**

Summary Budget Request Part A or MAI

Core Medical Services	Requested Amount	<u>All</u> Other Funding Sources for this Service and Amount(s)	Total Funding for this Service from all Your Sources
Outpatient/Ambulatory Health Services			
AIDS Pharmaceutical Assistance Local			
Oral Health Care			
Early Intervention Services (EIS)			
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals			
Mental Health Services			
Medical Nutrition Therapy			
Medical Case Management, including Treatment Adherence Services			
Substance Abuse Outpatient Care			
Support Services			
Non-Medical Case Management Services			
Emergency Financial Assistance - Food			
Emergency Financial Assistance - Utilities			
Emergency Financial Assistance - Pharmacy			
Emergency Financial Assistance - Housing			
Food Bank/Home Delivered Meals			
Health Education/Risk Reduction			
Other Professional Services (Legal Services)			

Linguistic Services			
Medical Transportation			
Outreach Services			
Psychosocial Support Services			
Substance Abuse Services (Residential)			
Total Amount Requested			

If you have staff positions that are funded fully or partially by Part B or other sources, and you are seeking Part A funding for these services, please explain how you will manage this to prevent double billing for those services.

Line Item Budget Request Part A or MAI

Service Category	Funding Request	Number of Units Provided	Anticipated Number of Clients to be Served
Total Service Funds Requested			
Administration			
Total Amount Requested			

Please insert a sheet directly behind this form which includes:

- Detailed narrative justification of Line Item Budget Request (including the components used to determine the amount requested for administration. If items are charged to administration they cannot also be calculated into cost per unit of service).

- Detailed formula for costs used to determine the requested cost per unit of service. Items that are included in the cost per unit cannot be charged to administration.