

Ryan White HIV/AIDS Program

Part A Manual

U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau

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Preface

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP) Part A Manual (hereinafter referred to as the Part A Manual) is an informational resource for RWHAP Part A recipients (i.e., those who receive RWHAP funds directly from the federal government) and their subrecipients. The RWHAP is administered by HAB, which is one of several [offices and bureaus in HRSA](#). HRSA is one of the [agencies within the U.S. Department of Health and Human Services \(HHS\)](#). HAB awards RWHAP Part A grants to the 52 Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most affected by the HIV epidemic in the United States. Approximately 72 percent of all people with diagnosed HIV in the United States are living in EMAs and TGAs¹.

The Part A Manual serves as:

- An orientation guide for new RWHAP Part A recipient staff, with sections explaining how the RWHAP Part A is structured at the jurisdictional level, and the key issues and strategies used by the RWHAP Part A to broaden access to HIV care and treatment to people in need;
- A reference document for RWHAP Part A recipient staff on legislative, grant regulation, and program requirements, including links to source documents;
- A guide for recipient staff responsible for the implementation and management of RWHAP Part A fiscal and program components, supporting and facilitating a planning council/planning body; and
- A source of information about where to obtain additional information and technical assistance (TA).

Summary of Changes

This manual includes the following key changes from the previous version (issued March 2025):

(2025)

- This manual reflects policies of the federal government as of March 2025, however, recipients of federal funds must always comply with the applicable legal requirements and policy directives in effect;
- Updating the manual to reflect full adoption of 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards; and
- Updating program reporting requirements.

(2024)

- Updates information to reflect recently published [HRSA HAB Policy](#)

¹ Health Resources and Services Administration, HIV/AIDS Bureau. 2021. HRSA's Ryan White HIV/AIDS Program Part A: Grants to Eligible Metropolitan and Transitional Areas Program Fact Sheet, September 2021. Available at <https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-a>. Accessed March 21, 2023.

Clarification Notices (PCNs);

- Updates language to reflect current RWHAP Part A policies and procedures;
- Restructures the manual to reduce duplication and increase readability; and
- Includes additional information to ensure recipient understanding of key issues, for example:
 - Section I, RWHAP Part A Funding, now includes a chart to further explain the duties of the chief elected official (CEO), recipient, and planning council/planning body;
 - Section IV, Clinical Quality Management, now includes an additional chapter on clinical quality management concepts to help guide and improve quality management programs;
 - Section V, Key Legislative Requirements, has more details to explain imposition of charges; and
 - Section VI, Reporting Requirements, now explains a comprehensive chart listing all reporting requirements in order by the deadline.

Routine Updates

HRSA HAB staff will review and update the RWHAP Part A Manual periodically. Recipients are encouraged to share recommendations for future enhancements to the manual or other feedback with their assigned HRSA HAB Project Officer (PO).

For questions about the RWHAP Part A Manual, staff should reach out to their assigned RWHAP Part A PO.

Section I: The Ryan White HIV/AIDS Program

I. Chapter 1. Overview

Landmark legislation created the RWHAP, the largest federal program, which is focused exclusively on providing care and treatment services to people with HIV. HRSA’s RWHAP has been vital to the public health response to HIV in the United States for the last four decades. The RWHAP provides a comprehensive system of HIV primary medical care, medication assistance, and essential support services to more than 50 percent of people diagnosed with HIV in the United States.² In 2023, 90.6 percent of RWHAP clients were virally suppressed,³ exceeding the national average of 65.1 percent.⁴

This contribution to public health cannot be understated because, unless people with HIV are effectively treated so they reach viral suppression, HIV can be transmitted to others and lead to premature death. In addition, the epidemic largely affects people who have low incomes, have limited or no access to health care, and who are people or disproportionately impacted by HIV. The RWHAP provides high-quality HIV care and treatment services to these people and communities.

Congress first enacted the RWHAP legislation in 1990 to improve the quality and availability of care for low-income and underserved individuals and families affected by HIV. As noted earlier, HRSA HAB administers the RWHAP. By legislation, the grant awards made under the RWHAP legislation may not be used for any item or service for which payment has been made, or can reasonably be expected to be made, under any state compensation program, under an insurance policy, or under any federal or state health benefits program (except for a program administered by or providing the services of the Indian Health Service (IHS)), referred to as “payor of last resort.”

I. Chapter 2. HRSA HAB

HRSA’s Office of the Associate Administrator (OAA) for HAB manages the bureau; provides leadership and direction for HRSA’s HIV/AIDS programs and activities, including the RWHAP; and oversees collaboration with other national health programs. The mission of HRSA HAB is to “provide leadership and resources to advance HIV care and treatment to improve health outcomes and reduce health disparities for people with HIV and affected communities.” The vision of HRSA HAB is “optimal HIV care and treatment for all to end the HIV epidemic in the

² U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. 2021. *Resilience and Innovation to End the HIV Epidemic in the U.S.: 2021 Ryan White HIV/AIDS Program Highlights*. Available at <https://ryanwhite.hrsa.gov/data/biennial-reports>. Accessed February 27, 2022.

³HRSA. Ryan White HIV/AIDS Program. 2020. *Ryan White HIV/AIDS Program Annual Client-Level Data Report 2020*. Available at <https://ryanwhite.hrsa.gov/data/reports>. Published December 2021.

⁴ Centers for Disease Control and Prevention. *2019 National HIV Surveillance System Reports*. Available at <https://www.cdc.gov/hiv/pdf/library/reports/surveillance-data-tables/vol-3-no-1/cdc-hiv-surveillance-tables-vol-3-no-1.pdf>. Accessed January 3, 2023.

U.S.” HAB plays a critical role in helping to diagnose, treat, prevent, and respond as part of the Ending the HIV Epidemic in the U.S. (EHE) initiative.

HRSA HAB has seven offices and divisions as described below and depicted in its organizational chart, available at: <https://www.hrsa.gov/about/organization/hab-org-chart.html>.

- **Office of the Associate Administrator (OAA)** – Manages HAB; provides leadership and direction for HRSA’s HIV programs and activities; provides training and technical assistance to staff on oversight and monitoring; and oversees collaboration with other national health programs;
- **Division of Metropolitan HIV/AIDS Programs (DMHAP)** – Administers the RWHAP Part A as well as the EHE initiative;
- **Division of State HIV/AIDS Programs (DSHAP)** – Administers the RWHAP Part B HIV Care Program, which includes RWHAP Part B Base, AIDS Drug Assistance Program (ADAP), ADAP Supplemental, Emerging Communities (EC), Minority AIDS Initiative (MAI), Part B Supplemental, and ADAP Emergency Relief Fund (ERF), and also administers a component of the EHE initiative;
- **Division of Community HIV/AIDS Programs (DCHAP)** – Administers the RWHAP Part C, RWHAP Part C Capacity Development, RWHAP Part D, and RWHAP Part F Community Based Dental Partnership Program (CBDPP), and Dental Reimbursement Program (DRP);
- **Division of Policy and Data (DPD)** – Provides leadership and expertise in RWHAP data management and analysis, policy development and implementation, program evaluation, technical assistance, publication development, and clinical quality management activities to support HRSA HAB’s mission. DPD also administers the RWHAP Part F Special Projects of National Significance (SPNS) Program;
- **Office of Operations and Management (OOM)** – Provides administrative and fiscal guidance and support for HRSA HAB and is responsible for all budget execution tasks, personnel actions, information technology, contracting services, and facility management; and
- **Office of Program Support (OPS)** – Provides grants management, communication, training, and crosscutting clinical expertise to drive excellence, innovation, and collaboration across HRSA HAB and administers the AIDS Education and Training Center (AETC) Program.

Division of Metropolitan HIV/AIDS Programs

HRSA HAB DMHAP administers the RWHAP Part A HIV Emergency Relief Grant Program as well as EHE cooperative agreements. At any given time, DMHAP also oversees a number of cooperative agreements and contracts that address issues of importance to the RWHAP Part A.

I. Chapter 3. RWHAP Legislation and Relevant Authorities

Congress first authorized and funded the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990. Since that time, it has been amended and reauthorized four times (in 1996, 2000, 2006) and, in 2009, as the Ryan White HIV/AIDS Treatment Extension Act of 2009 (codified in title XXVI of the Public Health Service (PHS) Act, 42 U.S.C. 300ff-11 et seq.), from here on referred to as the RWHAP legislation.

Congress adjusted the RWHAP legislation with each reauthorization to accommodate new and emerging needs, such as an increased emphasis on funding core medical services and changing funding formulas. The legislation provides the structure through which the RWHAP funding is distributed. Legislative provisions, called sections, address planning and decision-making, available grant types, allowable uses of funds, application eligibility and submission requirements, and TA to build capacity and help programs run more effectively (see <https://ryanwhite.hrsa.gov/about/legislation>).

The legislation provides a flexible structure to address HIV and AIDS care needs based on:

- Different geographic areas (large metropolitan areas, states/territories, and communities across the nation);
- Varying populations most affected by the epidemic;
- Availability and access to HIV-related services; and
- Service system needs (e.g., technical assistance for programs, training of clinicians, research on innovative models of care).

RWHAP Part A recipients not only must comply with the RWHAP legislation, but also must comply with all relevant authorities, including regulations and program-specific policies. Further details on relevant authorities as they pertain to key concepts can be found within this manual.

The relevant authorities are:

- RWHAP Legislation: <https://ryanwhite.hrsa.gov/about/legislation>
- The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, 2 CFR 200: <https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200?toc=1>
- HHS and HRSA Grants Administration and Program-Specific Policies:
 - HHS Grants Policy Statement (GPS): <https://www.hhs.gov/sites/default/files/grants/policies-regulations/hhsgps107.pdf>
 - Notices of Funding Opportunity (NOFOs): <https://www.hrsa.gov/grants/fundingopportunities/default.aspx>
 - Notices of Award (NoAs): <https://www.hrsa.gov/sites/default/files/grants/manage/awardmanagement/notice/noticeofaward.pdf>
 - HRSA HAB Policy Notices: <https://ryanwhite.hrsa.gov/grants/policy-notice>

- HRSA HAB Program Letters: <https://ryanwhite.hrsa.gov/grants/program-letters>
- RWHAP Manuals and Reports, including this RWHAP Part A Manual: <https://ryanwhite.hrsa.gov/grants/manage/recipient-resources>
- RWHAP technical assistance documents, including the RWHAP Parts A and B National Monitoring Standards (NMS): <https://ryanwhite.hrsa.gov/grants/manage/recipient-resources>

Recipients should have a clear understanding of these authorities and all requirements and the expectations therein. For more information on the relevant authorities and program-specific policies, see Section III, Chapter 2, Relevant Authorities.

I. Chapter 4. Overview of the Ryan White HIV/AIDS Program Parts

RWHAP is divided into several “Parts,” as outlined in the authorizing legislation. The Parts include Part A, Part B, Part C, Part D, and Part F.

RWHAP Part A – Eligible Metropolitan Areas and Transitional Grant Areas:

RWHAP Part A funds core medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs and TGAs are the cities/counties most severely affected by the HIV/AIDS epidemic. EMA eligibility requires an area to report more than 2,000 AIDS cases in the most recent five years. To be eligible as a TGA, an area must have 1,000 to 1,999 reported AIDS cases in the most recent five years. Both EMAs and TGAs must have a population of at least 50,000 people.

RWHAP Part A

The RWHAP Part A award includes three components:

- **Formula** funds are awarded based on the percent of total living case counts across all jurisdictions multiplied by the amount available for distribution;
- **Supplemental** funds are awarded based on scores from objective review; and
- **Minority AIDS Initiative (MAI)** are based on the percent of total living minority case counts across all jurisdictions multiplied by the amount available for distribution, funds support services for minority population as directed by the RWHAP statute.

RWHAP Part B – States/Territories:

RWHAP Part B administers funds for states and territories to improve the quality, availability, and organization of HIV health care and support services. Recipients include all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the six U.S. Pacific territories/associated jurisdictions. Funding for RWHAP Part B has various components:

- **RWHAP Part B HIV Care Grant Program** including:
 - *RWHAP Part B Base* funds to provide core medical and support services;

- ***RWHAP ADAP Base*** funds to provide Food and Drug Administration (FDA)-approved medications and purchase of health care coverage for low-income people with HIV with limited or no health coverage from private entities, Medicaid, or Medicare;
- ***RWHAP ADAP Supplemental*** funds for eligible applicants who choose to apply to address a severe need for medication;
- ***Emerging Communities (EC) Supplemental*** funds for eligible applicants to enhance a comprehensive array of core medical and support services in metropolitan statistical areas (MSAs) reporting between 500 and 999 cumulative AIDS cases over the most recent five years; and
- ***MAI*** funds to provide education and outreach services to improve minority access to medication assistance programs, including ADAP.
- **RWHAP Part B Supplemental Grant Program** for recipients with demonstrated need to supplement the HIV care and treatment services provided by the states/territories through RWHAP Part B, including ADAP.
- **ADAP Emergency Relief Funds (ERF)** to help states prevent, reduce, or eliminate ADAP waitlists or implement cost-containment measures.⁵

RWHAP Part C – Community-Based Programs:

RWHAP Part C administers funds directly to local, community-based organizations to provide comprehensive primary HIV medical care and support services in an outpatient setting for people with HIV through Early Intervention Services (EIS) program grants. RWHAP Part C also funds Capacity Development grants, which help organizations more effectively deliver HIV care and services.

RWHAP Part D – Women, Infants, Children, and Youth with HIV and their Families:

RWHAP Part D administers funds for local, community-based organizations to provide outpatient, ambulatory, family-centered primary and specialty medical care for women, infants, children, and youth (WICY) with HIV.

RWHAP Part F – Demonstration and Training:

RWHAP Part F funds support clinician training, technical assistance, and the development of innovative models of care to improve health outcomes and reduce HIV transmission. These programs include:

- **The Special Projects of National Significance (SPNS) Program** – Supports the development of innovative models of HIV care and treatment to respond to emerging needs of clients served by the RWHAPs. The SPNS program advances knowledge and skills in the delivery of health care and support services to people and communities disproportionately impacted by HIV and builds health information technology (HIT) capacity within the RWHAP community to report client-level data.
- **The AIDS Education and Training Center (AETC) Program** – Supports a network of eight regional centers (and more than 130 local affiliated sites) and two national centers

⁵ Authority for ADAP ERF is 311(c) of the PHS Act.

that conduct targeted, multidisciplinary education and training programs for health care providers treating people with HIV.

- **Dental Programs** – All RWHAP Parts can support the provision of oral health services; however, two RWHAP Part F programs focus on funding oral health care for people with HIV:
 - ***The HIV/AIDS Dental Reimbursement Program (DRP)*** reimburses dental schools, hospitals with postdoctoral dental education programs, and community colleges with dental hygiene programs for a portion of uncompensated costs incurred in providing oral health treatment to people with HIV.
 - ***The Community-Based Dental Partnership Program (CBDPP)*** supports increased access to oral health care services for people with HIV while providing education and clinical training for dental care providers, especially those practicing in community-based settings.

Section 2693 of the PHS Act states that the Minority AIDS Initiative (MAI) addresses the disproportionate impact of HIV and AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities (including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders). The MAI was codified in 2006 and provides additional funding under the RWHAP Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

- Under RWHAP Part A, MAI formula grants provide core medical and related support services to improve HIV-related health outcomes to reduce existing racial and ethnic health disparities;
- Under RWHAP Part B, MAI formula grants fund support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to treatment;
- Under RWHAP Part C, MAI funds are for the provision of culturally and linguistically appropriate care for racial and ethnic minorities;
- Under RWHAP Part D, MAI funds are for eliminating racial and ethnic disparities in the delivery of comprehensive, culturally, and linguistically appropriate HIV care services for WICY; and
- Under RWHAP Part F, MAI funds are for increasing the training capacity of AETCs to expand the number of health care professionals with treatment expertise and knowledge about the most appropriate standards of HIV-related treatments and medical care for racial and ethnic minority adults, adolescents, and children with HIV.

For more information on the RWHAP, see <https://ryanwhite.hrsa.gov/about>.

For Congressional appropriations by Part, see <https://ryanwhite.hrsa.gov/about/budget>.

I. Chapter 5. Context of the RWHAP

National HIV Goals

The national HIV goals are <https://www.hiv.gov/federal-response/national-hiv-aids-strategy/national-hiv-aids-strategy-2022-2025> a roadmap for stakeholders across the United States to accelerate efforts to end the HIV epidemic by 2030. RWHAP promotes robust advances and innovations in HIV health care using the national HIV goals as its framework to end the epidemic. Therefore, to the extent possible, activities funded by RWHAP focus on addressing the following four goals:

- 1) Prevent new HIV infections;
- 2) Improve HIV-related health outcomes for people with HIV;
- 3) Reduce HIV-related health disparities; and
- 4) Achieve integrated and coordinated efforts that address the HIV epidemic among all partners and stakeholders.

To achieve these shared goals, recipients should, within the parameters of the RWHAP legislation and program guidance, align organizational efforts to ensure that people with HIV are linked to and retained in care, and have timely access to HIV treatment and the supports needed (e.g., mental health and substance use disorder services) to reach HIV viral suppression.

Ending the HIV Epidemic in the U.S.

In February 2019, the Administration announced a new initiative, Ending the HIV Epidemic in the U.S. (EHE) (see <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>). This ongoing federal initiative began in FY 2020 and seeks to achieve the important goal of reducing new HIV infections in the United States to less than 3,000. Across the United States, this initiative includes four strategies to substantially reduce HIV transmissions:

- Diagnose all people with HIV as early as possible;
- Treat people with HIV rapidly and effectively to reach sustained viral suppression;
- Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs); and
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

I. Chapter 6. RWHAP Part A Funding

RWHAP Part A provides direct financial assistance to EMAs and TGAs that have been severely affected by the HIV epidemic. Grant funds assist eligible jurisdictions to develop or enhance access to a comprehensive continuum of high-quality, community-based care for people with HIV that are experiencing low income through the provision of formula, supplemental, and MAI funds. RWHAP Part A recipients must provide comprehensive primary health care and support

services throughout the entire designated geographic service area. The goal is to provide optimal HIV care and treatment for low-income and underserved people with HIV to improve their health outcomes.

At least 75 percent of direct service funds must be used for HIV core medical services (as defined by the RWHAP legislation), and up to 25 percent may be used for approved support services, unless the EMA or TGA receives a core medical services waiver. Up to 10 percent of the total grant can be used for administrative costs, which include planning, managing, monitoring, and evaluating the RWHAP in the EMA/TGA. Administrative funds are also used to support a comprehensive community planning process, through the work of a planning council or planning body. In addition, up to 5 percent of the total grant or \$3 million, whichever is less, can be set aside for clinical quality management to ensure service quality.

Beginning in FY 2022, the RWHAP Part A shifted from an annual competitive application program to a three-year period of performance. In the three-year period of performance, eligible applicants submit a competitive application in the first year and non-competing continuation (NCC) progress reports for years two and three. The competitive applications are reviewed via an objective review process and are scored based on standardized review criteria included in the NOFO.

An objective review is the process whereby subject matter experts (independent reviewers) objectively evaluate and score applications against published criteria. Objective reviews are managed by the Division of Independent Review (DIR) in the Office of Federal Assistance Management (OFAM) in HRSA. The normalized score from the objective review of the competitive application is utilized to calculate supplemental funding for both the competitive and non-competitive years.

Eligibility

Eligibility for RWHAP Part A grants is based in part on the number of confirmed AIDS cases within a statutorily specified metropolitan area. The Secretary uses the OMB's census-based definitions of a Metropolitan Statistical Area (MSA) in determining the geographic boundaries of a RWHAP metropolitan area. HHS utilizes the OMB geographic boundaries that were in effect when a jurisdiction was initially funded under RWHAP Part A.⁶ For all newly eligible areas, the boundaries are based on current OMB MSA boundary definitions.⁷

RWHAP Part A recipients that are classified as an EMA or TGA and continue to meet the status as an eligible area, as defined in statute, are eligible 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,⁸ and for a TGA, this is at least 1,000 but fewer than 2,000 cases of AIDS reported and confirmed during the most recent five calendar years for which such data are available.⁹ In addition, for three consecutive years, recipients must not have fallen below both the required incidence levels

⁶ Section 2601(c)(1) of the PHS Act.

⁷ Section 2601(c)(2) of the PHS Act.

⁸ Section 2601(b)(1a) of the PHS Act.

⁹ Section 2609(c)(2)(A)(i) of the PHS Act.

already specified and required prevalence levels (cumulative total of living cases of AIDS reported to and confirmed by the Director of the Centers for Disease Control and Prevention (CDC), as of December 31 of the most recent calendar year for which such data are available). For an EMA, the required prevalence is 3,000 living cases of AIDS.¹⁰ For a TGA, the required prevalence is 1,500 or more living cases of AIDS. However, for a TGA with five percent or less of the total amount from grants awarded to the area under RWHAP Part A unobligated, as of the end of the most recent fiscal year, the required prevalence is at least 1,400 (and fewer than 1,500) living cases of AIDS.¹¹ Should a RWHAP Part A lose status, funds are transferred to the state.¹²

Chief Elected Official, Recipient, and HIV Health Services Planning Council or Planning Body

RWHAP Part A funds are awarded to the Chief Elected Official (CEO) of the major city or county government in the EMA or TGA. The CEO is usually the mayor; however, sometimes the CEO is the county executive, chair of the board of supervisors, or county judge.

The legislation includes specific reference to CEO responsibilities:¹³

1. Establishing a mechanism to ensure that funds are allocated to all portions of the EMA or TGA, and
2. Establishing a planning council (PC)/planning body (PB) with requisite community input processes to best meet the needs of people with HIV.

The CEO is legally the recipient of the grant, but usually chooses a lead agency, such as a department of health or other entity, to manage the grant. That entity is also called the recipient. The recipient manages the grant by ensuring RWHAP funds are used according to the RWHAP legislation, regulation, program policy guidance, and federal grants policy. The recipient may contract its administrative and/or fiscal responsibilities to an outside entity. That entity, under legal contract, is responsible for carrying out the programmatic and/or fiscal responsibilities while acting on behalf of the recipient.

The CEO ensures that RWHAP partners meet their legislative requirements and submits written assurances to the federal government that requirements are being met. Assurances are submitted as part of the annual funding application or NCC submission to HAB DMHAP. CEO partners include the administrative agency designated by the CEO to oversee the program (e.g., the health department or other entity), the PC/PB, and its diverse voices of those with expertise and lived experiences of people with HIV. Other RWHAP partners include city or county finance or grants offices that disburse and account for funds.

As a condition for receiving RWHAP funds, the CEO for the EMA/TGA must appoint a PC or PB. Each EMA/TGA PC sets HIV-related service priorities and allocates RWHAP Part A funds

¹⁰ Section 2601(b)(2) of the PHS Act.

¹¹ Sections 2609(c)(2)(A)(ii) and (B) of the PHS Act.

¹² Section 2610 of the PHS Act.

¹³ Section 2602(a)(2)(A) of the PHS Act.

based on the size, demographics, and needs of people with or affected by HIV, with particular focus on individuals who know their HIV status but are not in care. TGAs established after 2006 have the option of not using a PC as their required community planning process. Rather, they may opt to utilize a PB, though HRSA HAB maintains many of the same expectations as it holds for a PC. (See [Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations Letter](#).)

The CEO, recipient, and PC/PB have specific roles and duties, some of which are a shared responsibility. The following chart outlines the responsibilities.

Figure 2. Roles/Duties of the Chief Elected Official, Recipient, and Planning Council/Planning Body

ROLE/DUTY	RESPONSIBILITY		
	CEO	Recipient	Planning Council/Planning Body
Establishment of PC/PB	✓		
Appointment of PC/PB Members	✓		
Needs Assessment		✓	✓
Integrated/Comprehensive Planning		✓	✓
Priority Setting			✓
Resource Allocations			✓
Directives			✓
Procurement of Services		✓	
Subrecipient Monitoring		✓	
Coordination of Services		✓	✓
Evaluation of Services: Performance, Outcomes, and Cost-Effectiveness		✓	<i>Optional</i>
Development of Service Standards		✓	✓
Clinical Quality Management		✓	<i>Contributes but not responsible</i>
Assessment of the Efficiency of the Administrative Mechanism			✓
Planning Council Operations and Support		✓	✓

I. Chapter 7. Technical Assistance, Links, and Resources

The RWHAP legislation authorizes technical assistance (TA) and a training component to help programs comply with the RWHAP requirements and support the work of RWHAP constituents, including recipients, providers, PBs, and clients¹⁴ to improve health care access and quality of life for people with HIV. Activities include provision of TA tools and documents, on-site and distance-based consultations, expert meetings, and specialized TA centers. HAB has developed policies and program guidance that incorporate both OMB regulations and program-specific requirements.

The following links provide additional information on HRSA HAB, the RWHAP legislation, policies, TA, and other related federal health care programs relevant to people with HIV.

HRSA HAB: <https://www.hrsa.gov/about/organization/bureaus/hab/index.html>. For more information about HRSA HAB and the implementation of the RWHAP.

RWHAP Legislation: <https://ryanwhite.hrsa.gov/about/legislation>. For more information about the RWHAP legislation as well as links to the PHS Act, Title XXVI.

RWHAP Recipient Resources: <https://ryanwhite.hrsa.gov/grants/manage/recipient-resources>. For resources available to support RWHAP-funded recipients in implementing federal grants and delivering HIV care and treatment services.

National Monitoring Standards: <https://ryanwhite.hrsa.gov/grants/manage/recipient-resources>. For more information about the National Monitoring Standards.

AHEAD Dashboard: <https://ahead.hiv.gov>. This interactive tool displays EHE indicator data for all 50 states with a focus on the 57 priority areas.

HIV in the United States at a Glance: <https://www.cdc.gov/hiv/statistics/overview/ataglance.html>. This website, hosted by the CDC, summarizes data on HIV prevalence and incidence in the United States.

In addition to the “self-help” TA available through various websites and links, the PO also is responsible for identifying and responding to the specific TA needs of recipients and PCs. TA is provided in many topic areas related to the legislative mandates and programmatic requirements of the RWHAP legislation through the following modalities:

¹⁴ “Client” is synonymous with “consumer” and is HRSA HAB’s preferred term.

- Individualized and on-site peer and expert consultation through a national Technical Assistance Contract (TAC). The TAC also coordinates consultative meetings and conferences, site visits, and conference calls;
- Assisting recipients in replicating successful SPNS projects to strengthen their capacity to deliver new methods of evidence-based HIV care. (See <https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-f-spns>); and
- An array of cooperative agreements with national organizations to deliver training and TA in specific topics through local and regional workshops, webcasts, web-based learning modules, conference calls, on-site trainings, and technical publications and curricula.

To obtain more information about TA, recipients should contact their HAB PO. Additional sources of TA are provided in other sections of this manual.

Section II: Planning and Delivery of HIV Services

II. Chapter 1. Overview

The RWHAP requires states/territories to develop comprehensive HIV care and treatment service delivery systems for low-income people with HIV by establishing and maintaining collaborative relationships on the state/territory and local levels among multiple sources of HIV testing, treatment, care, and prevention services agencies. RWHAP Part A recipients must use data to create systems that engage those people and communities disproportionately impacted by HIV.

RWHAP Part A recipients are required to improve client outcomes by building collaborative and coordinated partnerships among multiple sources of HIV testing, treatment, prevention, and care. Partnerships must be integrated into their HIV community-based needs assessment and planning processes so clients can experience a coordinated, comprehensive system of HIV prevention and care. RWHAP Part A core medical and support services funded under RWHAP Part A must be woven together, along with other non-RWHAP Part A-funded resources, to create a maximally seamless system that is responsive to the needs of populations in each jurisdiction. RWHAP recipients must integrate the national HIV goals and Early Identification of Individuals living with HIV (EIIHA) strategies in their plan to address the service needs of newly affected and underserved populations.

II. Chapter 2. Allowable RWHAP Service Categories

Section 2604(c)(1) of the PHS Act requires RWHAP Part A recipients to expend 75 percent of the grant funds, minus the amount reserved for administrative and clinical quality management (CQM) activities, on core medical services. In addition to core medical services, recipients may fund key support services needed to achieve medical outcomes. Section 2604(d) of the PHS Act defines support services as those “that are needed for individuals with HIV/AIDS to achieve their medical outcomes.”

HRSA HAB has defined and provided guidance on these 13 core medical services and 17 support services. (See PCN 16-02, Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Use of Funds at <https://ryanwhite.hrsa.gov/grants/policy-notice>.)

RWHAP services can only be used when there are no other sources of funding available for the service. Recipients fund a set of RWHAP core medical and support services as part of a comprehensive service delivery system for people with HIV to improve retention in medical care and viral suppression. To achieve these goals, recipients must use RWHAP Part A services with services from a variety of other payor sources that support medical, behavioral health, and supportive services.

Payor of Last Resort—Section 2605(a)(6) of the PHS Act:

“that funds received under a grant awarded under this subpart will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service-”

Core Medical Services

- ADAP Treatments
- AIDS Pharmaceutical Assistance
- Early Intervention Services
- Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
- Home and Community-Based Health Services
- Home Health Care
- Hospice Services
- Medical Case Management, including Treatment Adherence Services
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services
- Substance Abuse Disorder¹⁵ Outpatient Care

Support Services

- Child Care Services
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing
- Linguistic Services
- Medical Transportation
- Non-Medical Case Management Services
- Other Professional Services
- Outreach Services
- Psychosocial Support Services
- Referral for Health Care and Support Services
- Rehabilitation Services
- Respite Care
- Substance Abuse Disorder Services (residential)

Waiver of Core Medical Services Requirement

Section 2604(c)(2) of the PHS Act allows recipients to request a waiver of the 75 percent core medical services requirement if the recipient can demonstrate the availability of HIV core medical services for all identified and eligible people with HIV in the service area, and if there is not an ADAP waiting list in the state/territory.

¹⁵ “Substance Use Disorder” is HRSA HAB’s preferred terminology.

Applicants may submit a one-page HRSA RWHAP Core Medical Services Waiver Request Attestation Form to HRSA HAB, attesting that the underlying statutory and policy requirements for requesting a core medical services waiver have been met, with the grant application or NCC Progress Report. (See PCN 21-01, Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement, at <https://ryanwhite.hrsa.gov/grants/policy-notice>).

II. Chapter 3. RWHAP Part A Client Eligibility

Per [PCN #21-02](#), Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program, eligibility for RWHAP services is based on HIV status, low-income status (as defined by the recipient), and residency (as defined by the recipient). HRSA HAB expects all RWHAP recipients and subrecipients to establish, implement, and monitor policies and procedures to determine client eligibility based on these three factors. This expectation includes procedures and required documentation for initial eligibility determinations, and that eligibility confirmations of all enrolled clients are conducted to verify whether individuals remain eligible.

RWHAP Part A recipients are encouraged to coordinate eligibility requirements for RWHAP Part A services with other RWHAP-funded recipients in their jurisdiction to maximize access to care for people with HIV and to reduce administrative burden for direct service providers and clients. Recipients also are strongly encouraged to align confirmation processes with other health care coverage eligibility and enrollment processes that may exist. (See [PCN #13-03](#), Ryan White HIV/AIDS Program Client Eligibility Determinations: Considerations Post-Implementation of the Affordable Care Act, and [PCN #21-02](#), Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program). Establishing data-sharing agreements with other RWHAP recipients, RWHAP subrecipients, and federal programs can further reduce burden in eligibility and eligibility confirmation procedures.

II. Chapter 4. Comprehensive Planning and Collaboration

RWHAP services provide the support people with HIV need to access and remain engaged in HIV care and treatment services, with an ultimate goal of reaching viral suppression. The legislation allows jurisdictions to determine which core medical or support service to fund based on need. It also requires that jurisdictions ensure eligible people with HIV have uniform and equitable access to funded services. The RWHAP legislation requires a planning process that includes a data-driven approach and meaningful input by people with HIV and collaboration with other funding sources that provide HIV care and treatment.

Community Input and Coordination of Related Services

Each EMA/TGA PC or PB sets HIV-related service priorities and allocates RWHAP Part A funds based on the size, demographics, and needs of people with or affected by HIV, with particular focus on individuals who know their HIV status but are not in care.

To plan, establish, implement, and maintain a comprehensive HIV service delivery system, HRSA HAB requires RWHAP recipients to build collaborations, partnerships, and coordination mechanisms among multiple sources of HIV prevention, testing, treatment, and care service providers. Recipients and subrecipients are encouraged to establish agreements with key points of entry to enable referral and linkage of people with HIV to medical care and support services upon HIV diagnosis.

Sections 2602(b)(4)(G) and (H) of the PHS Act describe the PC role in assuring community input and coordinating with federal partners as follows:

(G) establish methods for obtaining input on community needs and priorities which may include public meetings (in accordance with paragraph (7)), conducting focus groups, and convening ad-hoc panels; and

(H) coordinate with Federal grantees that provide HIV-related services within the eligible area.

A comprehensive service delivery system also includes data collection and analysis mechanisms that allow providers to track the progress of individual clients, make data-informed healthcare decisions for those clients, and analyze the community-level impact of services.

Determining Need and Early Identification of Individuals with HIV/AIDS

Section 2602(b)(4) of the PHS Act requires the PC to determine the size and demographics of the population, as well as determine the needs of such population, including those who know their status and are not in care, as well as those who do not know their HIV status.

To meet EIIHA requirements, recipients must develop a comprehensive plan to:

- 1) Increase the number of individuals who are aware of their HIV status;
- 2) Increase the number of individuals with HIV who are in medical care; and
- 3) Increase the number of individuals without diagnosed HIV infection who are referred to prevention services.

The EIIHA Plan must include epidemiological data on the number of individuals with HIV, the estimated number of individuals with HIV who do not know their status, and activities that will be undertaken to meet EIIHA goals. The EIIHA Plan should align with the current Integrated HIV Prevention and Care Plan (Integrated Plan), including the Statewide Coordinated Statement of Need (SCSN).

Developing an Integrated HIV Prevention and Care Plan and Statewide Coordinated Statement of Need

Section 2602(b)(4)(F) of the PHS Act directs the PC to “participate in the development of the statewide coordinated statement of need initiated by the State public health agency responsible for administering grants under Part B.”

Section 2602(b)(4) of the PHS Act describes the PC duty to develop a comprehensive plan for the organization and delivery of health and support services, and participation in an SCSN.

Section 2602(b)(4)(D) of the PHS Act:

develop a comprehensive plan for the organization and delivery of health and support services in section 2604 that

- (i) *includes a strategy for identifying individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;*
- (ii) *includes a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse);*
- (iii) *is compatible with any State or local plan for the provision of services to individuals with HIV/AIDS; and*
- (iv) *includes a strategy, coordinated as appropriate with other community strategies and efforts, including 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 such status, and enabling such individuals to use the health and support services described in section 2604, with particular attention to reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities.*

In 2015, HRSA and CDC collaborated to create the Integrated Plan Guidance, including the SCSN, which addressed the legislative requirement for the SCSN and the comprehensive plan. The CDC and HRSA intentionally structured the guidance to require recipients to compile data to inform planning goals. Integrated data sets included HIV surveillance data, HIV care continuum data, client-level needs assessments, SCSN data, RWHAP data, and other relevant data sources as appropriate. Updated guidance for CY 2022-2026 further builds on the CDC and HRSA's efforts to:

- Reduce the reporting burden and duplicative efforts for recipients;
- Streamline the work of state/territory and local health department staff and HIV planning bodies; and
- Promote collaboration and coordination in the use of data while simultaneously allowing recipients to meet the submission requirements outlined in Sections 2617(b)(6) and (7) of the PHS Act.

See the [Integrated HIV Prevention and Care Plan Guidance - including the Statewide Coordinated Statement of Need CY 2027-2031](#) for additional information.

See Section III: Planning Council/Planning Body, Chapter 4, Roles and Responsibilities of the Planning Council and Planning Body, for additional information on the SCSN.

Collaboration with Key Points of Access

RWHAP legislation requires that RWHAP Part A recipients enter into intergovernmental agreements, develop a comprehensive plan, as well as collaborate with important points of access and components of the health care system for people with HIV.

Sections 2605(a)(2) and (3) of the PHS Act provide:

(2) that the eligible area has an HIV health services planning council and has entered into intergovernmental agreements pursuant to section 2602, and has developed or will develop the comprehensive plan in accordance with section 2602(b)(3)(B);

(3) that entities within the eligible area that receive funds under a grant under this subpart will maintain appropriate relationships with entities in the eligible area served that constitute key points of access to the health care system for individuals with HIV/AIDS (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health programs, and homeless shelters), and other entities under section 2604(b)(3) and 2652(a), for the purpose of facilitating early intervention for individuals newly diagnosed with HIV/AIDS and individuals knowledgeable of their HIV status but not in care.

II. Chapter 5. HIV Care Continuum

The HIV care continuum consists of five stages: Diagnosed, Receipt of Care, Retained in Care, Viral Suppression, and Linkage to Care.¹⁶ The HIV care continuum provides a framework that depicts the series of stages a person with HIV engages from initial diagnosis through successful treatment with HIV medication. It shows the proportion of individuals with HIV who are engaged at each stage. The HIV care continuum allows recipients and planning groups to measure progress and to direct HIV resources most effectively. Recipients are encouraged to assess the outcomes of their programs along this continuum of care.

Section 2605(a)(5) of the PHS Act states:

“that entities within the eligible area that will receive funds under a grant provided under section 2601 (a) shall participate in an established HIV community-based continuum of care if such a continuum exists within the eligible area;

RWHAP Part A recipients should work with HIV surveillance programs, community partners, and other federally funded programs to create a full data set that measures outcomes for people

¹⁶ HIV.gov. *What is the HIV Care Continuum?* <https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum>
Last updated June 21, 2021. Accessed April 2, 2022.

with HIV across the HIV care continuum. Additionally, HRSA recommends using variables (e.g., age, sex, race/ethnicity, and housing status) to stratify the data across the HIV care continuum as a means of identifying those subpopulations less likely to achieve improved health outcomes.

The PC/PB identifies specific service categories to fund based on annual assessment of the services and gaps in the HIV care continuum within a jurisdiction. Funded service categories should facilitate improvements at specific stages of the HIV care continuum. EMAs and TGAs should use a diagnosis-based HIV care continuum using CDC definitions. (See <https://www.cdc.gov/hiv/pdf/policies/progressreports/cdc-hiv-preventionprogressreport.pdf>.)

The CDC developed a public health strategy called “Data to Care,” which details ways to utilize HIV surveillance data, pharmacy fill data, clinic appointment data, and other treatment and care data sources to identify individuals with diagnosed HIV who are not in care, to link them to care, and inform the HIV care continuum.¹⁷ CDC’s Data to Care website has a variety of resources to assist state/territory and local health departments in using individual-level data to offer linkage and reengagement to care services when appropriate. Together, these resources provide additional examples of the ways in which recipients can use data to inform strategies to create a comprehensive system of care across the HIV care continuum.

¹⁷ Centers for Disease Control and Prevention Data to Care website at <https://www.cdc.gov/hiv/effective-interventions/treat/data-to-care?Sort=Title%3A%3Aasc&Intervention%20Name=Data%20to%20Care>. Accessed March 17, 2022.

Section III. Planning Council/Planning Body

III. Chapter 1. Overview

The PC works in partnership with the recipient, but *not* under its direction. The PC must be given full authority and support to carry out its legislatively mandated roles and responsibilities. While the authority to appoint the PC is clearly vested in the CEO, the PC is not advisory in nature. The PC has legislatively provided authority to make determinations and carry out its duties, independent from but in coordination with the recipient.

While most RWHAP Part A jurisdictions have a PC, TGAs established after 2006 may utilize a PB. A PB is required to provide a process for obtaining community input from people with lived experience. There is a distinction between the two types of bodies – the PC has specific legislative authority to make decisions, while the PB makes informed recommendations. Programmatically, however, HAB DMHAP holds both entities to many of the same standards in operation.¹⁸

III. Chapter 2. Legislative Background

Section 2602(b)(1) of the PHS Act requires the CEO to “establish or designate an HIV health services planning council that shall reflect in its composition the demographics of the population of individuals with HIV/AIDS in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations.”

Section 2609(d)(1)(A) of the PHS Act states a PB must detail the process used to obtain community input for formulating the overall plan for priority setting and allocating funds. HRSA HAB maintains many of the same expectations for PBs as it holds for PCs. (See the 2023 [Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectations Letter](#).)

An important responsibility for RWHAP Part A entities is to provide programs that contribute to improved health outcomes in the most cost-efficient manner. Section 2602(b)(4)(C)(ii) of the PHS Act requires RWHAP Part A PCs to establish priorities for the allocation of funds, including how best to meet priorities, considering factors such as demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and interventions. Similarly, Section 2603(b)(1)(D) of the PHS Act requires supplemental grants to be based on applications that demonstrate the ability to utilize “supplemental financial resources in a manner that is immediately responsive and cost-effective.”

¹⁸ HRSA HAB Letter to RWHAP Part A Grantees, 2022. Available at <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/planning-council-planning-body-requirements-expectations.pdf>.

The RWHAP legislation specifies a number of mandated activities that a PC must accomplish, other requirements, and prohibitions related to their operations. Section 2602(b)(5)(A) of the PHS Act prohibits a PC from being “directly involved in the administration of a grant” and does not permit it to “designate (or otherwise be involved in the selection of) particular entities as [sub]recipients” of RWHAP Part A funds. The RWHAP legislation also requires the PC to address grievances in their bylaws and prohibits them from being “chaired solely by an employee of the grantee.”¹⁹

Section 2602(b)(4)(C) of the PHS Act requires PCs to “establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant.” When establishing service priorities and the allocation of resources, PCs must consider relevant legislative funding requirements, such as the requirement that at least 75 percent of funds be spent on core medical services per Section 2604(c)(1) of the PHS Act.

The remaining chapters in this Section III detail all of the legislative requirements related to a PC and programmatic requirements related to a PB.

III. Chapter 3. Composition of the Planning Council/Planning Body

It is a legislative requirement and programmatic expectation that PC/PB membership reflect the demographics of the population of individuals with HIV in the EMA/TGA. Special consideration must be given to historically underserved populations and those experiencing significant disparities in access to services. It is a legislative requirement and programmatic expectation that no less than 33 percent of members be people with HIV who receive RWHAP Part A services (in the case of minors, this would include their caregivers) and who are unaffiliated with subrecipient provider agencies. PC membership must (and PB membership should) meet these requirements to ensure a representative planning body.

HRSA HAB recognizes that a PC/PB may perform planning activities for HIV prevention and care as well as other related infectious diseases; however, the RWHAP legislative and programmatic requirements still apply.

Reflectiveness

Reflectiveness is the extent to which the demographics of the PC/PB membership look like the epidemic of HIV in the EMA/TGA. Section 2602(b)(1) of the PHS Act requires a RWHAP Part A PC to “reflect in its composition the demographics of the population of individuals with HIV/AIDS in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations.” Reflectiveness is required for the whole PC as well as the client membership and is a programmatic expectation for a PB.

¹⁹ Sections 2602(b)(6), (7)(A) of the PHS Act.

Representation

The PC must include at least one member to separately represent each of the designated membership categories (unless no entity from that category exists in the EMA/TGA). Separate representation means that each member can fill only one legislatively required membership category at any given time, even if qualified to fill more than one. As membership on the PC changes, an individual member may be appointed by the CEO to another representation category to meet legislative requirements. Section 2602(b)(2) of the PHS Act lists 13 specific membership categories that must be represented on the PC. The membership categories include:

- A. health care providers, including federally qualified health centers;
- B. community-based organizations serving affected populations and AIDS service organizations;
- C. social service providers, including providers of housing and homeless services;
- D. mental health and substance [use] providers [*considered two separate categories*];
- E. local public health agencies;
- F. hospital planning agencies or health care planning agencies;
- G. affected communities, including people with HIV, members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C and historically underserved groups and subpopulations;
- H. non-elected community leaders;
- I. State government (including the State [M]edicaid agency and the agency administering the program under [P]art B) [*considered two separate categories*];
- J. grantees under subpart II of [P]art C;
- K. grantees under section 2671 [Part D], or, if none are operating in the area, representatives of organizations with a history of serving children, youth, women, and families living with HIV and operating in the area;
- L. grantees of other Federal HIV programs, including but not limited to providers of HIV prevention services; and
- M. representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding 3 years, and had HIV as of the date on which the individuals were so released.

It is a HRSA HAB expectation that, at a minimum, the PB must include representatives of each of the various stakeholders in the TGA. HRSA HAB defines stakeholder representation based on the above 13 membership categories required for a PC.

There are three exceptions to the rule on separate representation:

- 1) One person may represent both the substance use provider and the mental health provider categories if their agency provides both types of services and the person is familiar with both programs;

- 2) A single PC member may represent both the RWHAP Part B and the state Medicaid agency if that person is in a position of responsibility for both programs; and
- 3) One person can represent any combination of RWHAP Part F grant recipients (SPNS, AETCs, and dental programs) and Housing Opportunities for Persons with HIV/AIDS (HOPWA), if the agency represented by the member receives grants from some combination of those four funding streams (e.g., a provider that receives both HOPWA and SPNS funding), and the individual is familiar with all these programs.

In the event a jurisdiction does not have or is unable to fill a required membership category, documentation of efforts to fill the category, including annual certification by the CEO or designee, must be submitted to HRSA with the Annual Progress Report in the electronic handbooks (EHB).

Clients

Section 2602(b)(5)(C) of the PHS Act states that no less than 33 percent of the members must be unaffiliated clients who:

- “are receiving HIV-related services” from RWHAP Part A-funded providers;
- “are not officers, employees, or consultants” to any providers receiving RWHAP Part A funds and “do not represent any such entity”; and
- “reflect the demographics of the population of individuals with HIV/AIDS” in the EMA/TGA.

This means that the demographics of the HIV epidemic must be reflected by the whole PC membership and by the client membership. (Client is synonymous with the term consumer.) The PB, at a minimum, must include representatives of the various stakeholders in the TGA, and must reflect the demographics of the population of individuals with HIV in the jurisdiction. In addition, for a PC/PB, at least two of these client representatives must be willing to disclose their HIV status to the PC/PB in order to meet the legislative and programmatic requirement for representation. Other disclosures can remain within confidentiality procedures of the nomination and appointment process of the PC/PB.

Obtaining and maintaining effective involvement of people with HIV has major benefits but can also be a challenge. Barriers to eliciting and maintaining such involvement include time constraints, complex planning duties, costs of participation, and health concerns. Recruitment measures using a variety of outreach techniques are needed to identify clients prepared to serve actively on the PC/PB. Retention measures are needed to help members stay engaged and participate fully, such as orientation and training, mentoring, and financial support for the costs of PC participation.

RWHAP Part A funds cannot be used to provide cash payments such as stipends or honoraria. Rather, payments must represent reimbursements for actual allowable expenses, supported by documentation. Generally, reimbursement for expenses incurred is provided only for unaffiliated client members of the PC.

Non-Member Involvement of People with HIV

All PCs should incorporate input from people with HIV who are not members, as only a small number of individuals with HIV are appointed members, and they cannot fully represent the entire client community. PCs can more effectively enhance community and public input by:

- 1) Welcoming the people with HIV community to open PC and committee meetings;
- 2) Providing a public comment period at each meeting;
- 3) Opening non-governance committees (e.g., Needs Assessment) to non-members;
- 4) Codifying in its bylaws a standing committee of clients or people with HIV, with its membership including both formal PC/PB members and non-members;
- 5) Providing people with HIV opportunities for input into RWHAP Part A needs assessment and comprehensive planning processes through methods like town hall/community meetings, sessions, and formal communication structures with people with HIV caucuses and support groups, call-in opportunities, and use of social media, and focus groups;
- 6) Involving non-members on task forces and work groups so they can have an active voice in the process without making long-term commitments; and
- 7) Providing regular feedback and information access to appropriate segments of the people with HIV community.

Non-members cannot chair committees or serve on the Executive Committee of the PC/PB. RWHAP Part A funds cannot be used to reimburse expenses of non-members to attend PC/PB meetings as observers. However, the PC/PB can reimburse actual expenses related to attending meetings for clients who serve on committees or task forces or make requested presentations.

III. Chapter 4. Roles and Responsibilities of the Planning Council and Planning Body

The PC/PB cannot carry out its responsibilities without the help of the recipient, and the recipient cannot carry out its responsibilities without the help of the PC/PB. Some of these responsibilities are identified clearly in the RWHAP legislation. Others must be decided locally. It is important that the PC/PB and the recipient work together and come to an agreement about their responsibilities. This agreement should be written in an MOU between the recipient and the PC/PB.

The PC/PB and the recipient identify the needs of people with HIV by conducting a needs assessment and preparing and Integrated HIV Prevention and Care Plan. Both also ensure that other sources of funding work well with RWHAP funds and that RWHAP is the payor of last resort. Coordination of services and the development of service standards also are shared responsibilities. While the PC/PB contributes to CQM, the recipient ultimately is responsible for all activities pertaining to the CQM plan.

A primary task of the PC/PB is to conduct a needs assessment collaboratively with the recipient to determine which RWHAP Part A services are needed in the jurisdiction and which populations should be prioritized. Based on the needs assessment, the PC/PB decides what

services to fund in the EMA/TGA (priority setting) and decides how much of the RWHAP Part A award should be used for each of these services (resource allocation). The PC/PB works with the recipient to develop a long-term plan on how to provide these services (comprehensive plan). The PC/PB also looks for ways RWHAP Part A services work to fill gaps in care with other RWHAP Parts (through the SCSN as well as other services like Medicaid and Medicare coordination). The PC/PB also evaluates how efficiently providers are selected and paid (assessment of the efficiency of the administrative mechanism).

Per Section 2602(b)(4) of the PHS Act, the duties of the PC are as follows (these duties also apply to the PB per Section 2609(d)(1)(A) and HRSA HAB policy letters):

- a. Determine the **size and demographics** of the population of individuals with HIV and AIDS;
- b. Determine the **needs** of such population, with particular attention to individuals who know their status but are not in care, disparities in access to services, and individuals with HIV and AIDS who do not know their HIV status;
- c. Establish **priorities** for the allocation of funds within the eligible area, how to best meet each such priority, as well as additional factors to consider when allocating RWHAP Part A grant funds;
- d. Develop a **comprehensive plan** for the organization and delivery of health and support services;
- e. Assess the **efficiency of the administrative mechanism** in rapidly allocating funds to the areas of greatest need within the EMA/TGA, and assess the effectiveness of the services offered in meeting the identified needs, if/as needed;
- f. Participate in the development of the **Statewide Coordinated Statement of Need** initiated by the state public health agency;
- g. Establish methods for obtaining **community input** regarding needs and priorities; and
- h. **Coordinate with** other federal grantees that provide HIV-related service in the EMA/TGA.

Needs Assessment

Needs assessment is defined as a process of collecting information about the needs of people with HIV, both those receiving care and those not in care. Steps involve gathering data from multiple sources on the number of HIV and AIDS cases through an epidemiological profile. These data are typically provided by the local or state/territory health department and are used by the PC/PB to determine the needs of people with HIV, service barriers and gaps along the HIV care continuum, and current resources (RWHAP and other public/private) available to meet those needs.

If there are gaps in the needs assessment's ability to reach and address the needs of people with HIV or emerging communities (e.g., insufficient access points), the PC/PB and recipient must address capacity development needs.

RWHAP resources are only one source of HIV care. Therefore, needs assessments should identify where coordination across services is needed to identify individuals with HIV who do

not know their status and individuals who know their status but are not receiving HIV primary health care. For example, coordination with HIV prevention and with substance use prevention and treatment programs, including programs that provide comprehensive substance use treatment, can enhance efforts, provide risk reduction services to these individuals, enable them to access and remain in care, and better address the full range of service needs.

Many needs assessments have primarily focused on people with HIV who were receiving HIV-related services (individuals already “in care”). The RWHAP legislation requires PCs to expand their needs assessments to also determine the needs of those individuals who know their HIV status but are not in care, and to determine strategies for identifying individuals with HIV who do not know their status and ensuring that they are tested and linked to care. Section 2602(b)(4)(B)(ii) of the PHS Act states particular attention must also be paid to identifying “disparities in access and services among affected subpopulations and historically underserved communities.”

The needs assessment should be a joint effort between the PC/PB and the recipient, with the PC/PB having the lead responsibility. Some PCs/PBs use contractors to conduct the needs assessment, which is an administrative cost. Regardless of who performs the work, it must include direct input from a diverse group of people with HIV.

HAB DMHAP recommends EMAs/TGAs align their needs assessment cycle with the Integrated HIV Prevention and Care Plan or with the three-year period of performance when possible. If using the Integrated Plan needs assessment cycle, the comprehensive needs assessment should inform the Integrated Plan with focused assessments in the subsequent years. If using the three-year needs assessment cycle, the comprehensive needs assessment should inform the competitive application or year one of the three-year cycle with focused assessments in subsequent years. This practice allows focus on high-impact populations and an update on the resource inventory that will support annual priority setting and resource allocation activities. Epidemiologic data should be obtained annually as part of that process in evaluating the progress of the Integrated HIV Prevention and Care Plan that supports decision-making for reallocation and Priority Setting and Resource Allocation (PSRA).

Priority Setting and Resource Allocation

PSRA is *the single most important legislative responsibility of a PC/PB*; it greatly influences the system of HIV care in the EMA/TGA. Needs assessment data and data from other sources such as service cost, utilization data, and amounts paid by Medicaid and other private funders are used by the PC/PB to set priorities and allocate resources.

HAB DMHAP has established four components to the annual PSRA process:

1. Priority setting is the process of deciding which HIV services are the most important according to the criteria established in the EMA/TGA. All RWHAP Part A services **must be prioritized annually**;
2. Guidance to the recipient on how best to meet priorities, sometimes referred to as “directives,” involves instructions for the recipient to follow in developing requirements

for subrecipients in the provision of RWHAP HIV core medical and support services. This guidance usually addresses populations to be served, geographic areas to be served, and/or service models or strategies to be utilized;

3. Resource allocation is the process of distributing available RWHAP Part A program funds across the prioritized HIV service categories. Through resource allocation, the PC/PB instructs the recipient how to distribute the funds among RWHAP HIV core medical and support services; and
4. Reallocation is the process of moving program funds across RWHAP HIV service categories after the initial allocations are made. This may occur during the budget period when funds are underspent in some service categories and additional needs exist in other service categories. The PC/PB must approve such reallocations, unless the PC/PB has an agreement with the recipient allowing the recipient to reallocate funds across service categories.

Based on the findings of the needs assessment, the PC/PB establishes priorities for the provision of HIV services in the local community. Service priorities are based on:

- The size and demographics of the population of individuals with HIV and their needs, including those who know their HIV status but are not in care;
- Compliance with the legislative requirement to use not less than 75 percent of funds to provide core medical services, unless a waiver has been approved;
- Cost effectiveness and outcome effectiveness of proposed services and strategies
- Priorities of people with HIV for whom services are intended;
- Coordination of services with programs for HIV prevention and treatment of substance use;
- Availability of other governmental and non-governmental resources in the service area; and
- Capacity development needs, resulting from disparities in the availability of services for people with HIV with highest need.

Only HIV core medical services and support services included in the RWHAP legislation can be prioritized,²⁰ and **all** RWHAP core medical and support services **must be prioritized annually.**²¹

HSRA HAB strongly encourages PCs and PBs to ensure that prioritized services meet the specific needs of MAI subpopulations with the greatest need. To be effective, MAI service provision should employ the use of population-tailored, innovative approaches or interventions by specifically addressing the unique needs of MAI subpopulations most disproportionately impacted by HIV²² with the goal of reaching viral suppression among identified minority subpopulations.

The PC/PB does not have to allocate funding to all prioritized core medical and support services. Typically, the PC/PB makes resource allocations based on three funding scenarios for the

²⁰ Section 2604(a)(1) of the PHS Act.

²¹ Section 2602(b)(4)(C) of the PHS Act.

²² Section 2693(b)(2)(A) of the PHS Act

upcoming fiscal year to account for potential increases, decreases, or level funding. This eliminates the need for reallocation once the final NoA is received, which would further delay contracting once the final NoA is received. The recipient will use one of the three PC/PB allocation scenarios to allocate the final award.

The PC/PB makes resource allocations in accordance with the legislative requirement to use not less than 75 percent of funds to provide core medical services.²³ The PSRA process involves the PC/PB in determining how much funding will be dedicated to each service category, as well as any directives deemed necessary for such services. The PC/PB may review requests for proposals (RFPs) to ensure that the PC/PB's directives are properly reflected. The PC/PB does not, however, select the providers to deliver services nor participate in the management of subawards.

The PC/PB must provide the recipient with the results of the PSRA process, both to include in the RWHAP Part A application or NCC and as a basis for the selection of subrecipients during the procurement process. The grant application must demonstrate that grant funds were expended in accordance with the priorities that were established by the PC/PB.²⁴ The letter of assurance submitted with the application must be signed by the PC/PB chair or co-chairs and must indicate that formula, supplemental, and MAI funds awarded to the EMA/TGA are being expended according to the priorities established by the PC/PB.

At any time during the fiscal year, the PC/PB may be asked to approve the reallocation of funds across service categories. Data provided by the recipient can help the PC/PB evaluate the expenditure patterns within the EMA/TGA as a whole, as well as for specific service categories. If money is not being spent in an efficient manner, the PC/PB can reallocate funds to another service category within the current budget period. As a best practice and to facilitate the effective programming and use of funds through "rapid reallocation," the recipient and PC/PB should put in place an agreement allowing for a redistribution of funds within a certain percentage or absolute dollar amount for previously established service priorities.

Statewide Coordinated Statement of Need and Comprehensive Plan

The RWHAP legislation directs the PC to participate in the development of the SCSN and to develop a comprehensive plan for the organization and delivery of health and support services.²⁵ (See Section II, Chapter 2 of the Part A Manual.)

The PC, in conjunction with the recipient, develops a comprehensive plan to serve as a jurisdictional HIV strategy guiding all HIV-related resources for the jurisdiction. This responsibility is included under the requirement to submit an Integrated HIV Prevention and Care Plan (Integrated Plan), including the SCSN, as per HRSA and CDC guidance. Guidance for the current Integrated Plan covers years 2027-2031 and can be found here: [Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2027- 2031](#).

²³ Section 2604(c)(1) of the PHS Act.

²⁴ Section 2603(d) of the PHS Act.

²⁵ Sections 2602(b)(4)(D), (F) of the PHS Act.

The PC shares responsibility with the recipient for ensuring that RWHAP Part A-funded services are coordinated with other programs and services to provide a comprehensive continuum of care for people with HIV. This includes looking for ways that RWHAP Part A services can work with other RWHAP Parts and non-RWHAP organizations to fill gaps in care. The PC learns about service needs and gaps from the perspective of all RWHAP Parts through the SCSN that is developed under the coordination of the RWHAP Part B recipient, where special attention is given to early intervention services, HIV prevention, substance use prevention and treatment, and ongoing coordination with other services.

Coordination with Other Funds and Services

Although they usually operate fairly independently, RWHAP Part A PCs must work together with RWHAP Part B recipients, PBs, and consortia in pursuit of common goals to strengthen the service continuum for people with HIV. The PC is responsible for ensuring that RWHAP Part A resource allocation decisions account for and are coordinated with other funds and services. The planning tasks (needs assessment, PSRA, integrated/comprehensive planning) require getting substantial input, including identifying what other sources of funding exist. For example, the needs assessment should identify what HIV prevention and substance use treatment services already exist. Integrated/comprehensive planning helps the PC consider the changing healthcare landscape and the implications for HIV services. This information helps avoid duplication in spending and reduces gaps in care. More practical benefits can include reduced administrative and planning costs and less duplication of effort.

Coordination efforts are driven by recipient initiative and RWHAP requirements, such as cross-part membership in planning groups, consistency across state/territory and local Integrated Plans, and joint work on the SCSN. Among the more visible areas of coordination are pharmaceutical assistance and use of ADAP dollars in RWHAP Part A jurisdictions and/or RWHAP Part A contributions to state/territory ADAPs. Other areas for coordination with RWHAP Part B include state/territory programs like Medicaid and substance use prevention/treatment/disorder block grants. Tools to streamline planning and enhance services might be jointly developed, thus benefiting providers who are funded under both RWHAP Parts.

Coordination across RWHAP Parts A and B can occur on multiple levels, from less formal information sharing to more structured efforts, such as:

- Cooperation on planning-related tasks (e.g., needs assessment, comprehensive plans);
- Joint service-related tasks (e.g., design of data collection processes, standards of care, quality management, evaluation); and
- Consolidation or merger of planning bodies.

Service Standards

Service standards guide subrecipient providers in implementing funded services. They typically address the elements and expectations for service delivery, such as service components, intake and eligibility, personnel qualifications, and client rights and responsibilities. The service standards set the minimal level of service or care that a RWHAP-funded subrecipient provider may offer within a jurisdiction and serve as a base on which the recipient's CQM program is built. Developing service standards is usually a joint activity; the PC works with the recipient, providers, clients, and experts on particular service categories. While it is ultimately the responsibility of the recipient to ensure that service standards are in place, the PC typically takes the lead in developing service standards for funded service categories. These service standards must be consistent with [HHS guidelines on HIV care and treatment](#) as well as HRSA HAB standards and performance measures, including the National Monitoring Standards (NMS). Service standards need to establish the minimum requirement for service provision and comply with HAB PCNs.

Efficiency of the Administrative Mechanism

Section 2602(b)(4)(E) of the PHS Act requires a PC to “assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, and at the discretion of the [PC], assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs.” Section 2609(d)(1)(a) of the PHS Act requires a PB to establish a PSRA process and, as such, HRSA HAB also requires the PB to assess the administrative mechanism.

A PC/PB must conduct an annual assessment of the administrative mechanism to ensure that services are being funded as indicated by PC/PB priorities, that funds are contracted in a timely and transparent process, and subrecipient providers are reimbursed in a timely manner. All requirements that are not being met in an EMA/TGA should be documented, and a corrective action plan (CAP) should be implemented. The PC/PB signs an assurance that is submitted with the competitive application and NCC that the assessment of grant recipient activities ensured timely allocation/contracting of funds and payments to subrecipient providers.

III. Chapter 5. Planning Council and Planning Body Operations

The PC/PB (and its support staff) carry out complex tasks to ensure smooth and fair operations and processes. The development of bylaws, policies and procedures, memoranda of understanding, grievance procedures, and trainings are crucial for the success of the PC/PB. The work also involves establishing and maintaining a productive working relationship with the recipient, developing and managing a budget, and ensuring necessary staff support to accomplish the work. Establishing and operationalizing these policies, procedures, and systems facilitates the ability of the PC/PB to effectively meet its legislative duties and programmatic expectations.

Planning Council/Planning Body Support

The PC/PB must carry out many complicated planning activities to assess the service needs of people with HIV living in the EMA/TGA and specify the kinds and amounts of services

required to meet those needs. PC/PB support assists with fulfilling these activities and tasks by providing for the hiring of staff or consultants.

Funds used for PC/PB support are part of the 10 percent administrative cost cap of the RWHAP Part A award.²⁶ The PC/PB must negotiate the size of its support budget with the recipient to carry out its legislative and programmatic responsibilities and then is responsible for developing and managing said budget within the recipient's grants management structure. PC/PB support funds may be used for such purposes as hiring staff, developing and carrying out needs assessments and estimating unmet need (sometimes with the help of consultants), conducting planning activities, holding meetings, and assuring participation of people with HIV.

The procedures to be used in hiring PC/PB support staff or contracting with consultants need to be agreed upon between the PC/PB and the recipient in advance of hiring or contracting support and should be included as a part of the MOU between the PC/PB and the recipient. Though support staff may be employed by the recipient, measures must be taken to ensure that the PC/PB, not the recipient, directs the work of such support staff and that the PC/PB maintains a mechanism for evaluating support staff performance.

HAB DMHAP has always discouraged the practice of having the same staff person perform work for the recipient and provide support to the PC/PB. However, HAB recognizes that there may be times, because of limited funds, when this situation may be unavoidable. The challenge presented in such situations is to balance the dual role of providing the PC/PB with full authority and autonomy to carry out its mandated responsibilities while also performing the duties of the recipient. Having a single staff member perform dual roles could compromise objectivity and lead to the recipient having undue and improper influence or control over the PSRA process and other PC/PB programmatic responsibilities.

Bylaws

Each PC/PB must have written rules, called bylaws, which explain how the PC/PB will conduct its business.²⁷ Bylaws must be clear and exact and include the following:

- Mission of the PC/PB;
- Member terms and how members are selected (open nominations process);
- Duties of members;
- Officers and their duties;
- How meetings are announced and run, including how decisions are made and recorded in the minutes;
- What committees the PC/PB has and how they operate;
- Conflict of Interest Policy;
- Grievance Procedures;
- Code of Conduct for members; and
- How the bylaws can be amended.

²⁶ Section 2604(h)(3)(B) of the PHS Act.

²⁷ Section 2602(b)(6) of the PHS Act.

Policies and Procedures

The ability of the PC/PB to carry out its legislative and programmatic responsibilities depends on structure that includes comprehensive policies and procedures that are subject to periodic review and revision to resolve issues in a timely and appropriate manner. PC/PB policies and procedures should, at a minimum, include:

- Review of service standards;
- Review of bylaws, the approval process, and signature;
- Nominations for members based on an open process, with criteria clearly stated and publicized, including a conflict of interest standard;
- Orientation and training for PC/PB members so they are able to fully participate in PC/PB meetings and demonstrate competencies for legislative and programmatic requirements of PCs/PBs;
- Leadership policies and procedures ensuring the PC/PB is not chaired solely by an employee of the recipient, PC/PB meetings are open to the public, and meeting minutes that protect the medical privacy of individuals are publicly available;
- Representation, reflectiveness, and client membership are essential to fulfilling legislative and programmatic requirements on PC/PB membership, i.e., 33 percent of members, compliance validated by the chair or co-chairs, must be clients of RWHAP services who are unaffiliated with funded providers;
- Grievance procedures with respect to funding decisions, including procedures for submitting grievances that cannot be resolved informally or by mediation to binding arbitration; and
- PC/PB member expense reimbursement for attending PC/PB meetings, travel, and childcare in accordance with HRSA HAB guidance on limitations.

Conflict of Interest

A conflict of interest can be defined as an actual or perceived interest in an action that will result—or has the appearance of resulting—in personal, organizational, or professional gain. As appropriate, the definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. Any group making funding decisions for the RWHAP Part A should be free from conflicts of interest; when conflicts do exist, members must abstain from the discussion and voting, and abstentions should be noted in the meeting minutes.

While the CEO may designate a specific department within local government to administer the RWHAP Part A award, it is not appropriate for the recipient to perform duties related to the PC/PB legislative and programmatic responsibilities. To preserve the independence of the PC/PB, a separation of PC/PB and recipient roles is necessary to avoid conflicts of interest. Recipient staff administer the RWHAP Part A grant in their jurisdiction (including selection of subrecipients to provide services); moreover, the PC is prohibited from administering the RWHAP Part A grant,

including the designation or selection of subrecipients.²⁸ As such, recipient staff cannot have a voting role in the PC to avoid this conflict of interest, and it is HRSA’s expectation that jurisdictions with PBs do not include recipient staff in a voting role.

A separation of PC/PB and recipient roles is necessary to avoid conflicts of interest. The legislation prohibits PC public deliberations from being “chaired solely by an employee of the grantee.”²⁹ A recipient representative, whose position is funded with RWHAP Part A funds, provides in-kind services, or has significant involvement in the RWHAP Part A grant, shall not occupy a voting seat in the PC/PB. A recipient representative may serve as a non-voting co-chair of the PC/PB.

If a member of the PC/PB has a financial interest, is an employee, or is a member of an organization seeking RWHAP Part A funds, the PC/PB member cannot participate (directly or in an advisory capacity) in the process of selecting subrecipients/providers.³⁰

Memorandum of Understanding

To clarify the roles of the PC/PB and the recipient and to encourage a collaborative working relationship, HAB DMHAP recommends the development of a written agreement or a Memorandum of Understanding (MOU). The MOU should identify the individual and shared responsibilities of both parties, provide a timeline for sharing information or reports that will be regularly provided, and specify communication mechanisms and a process for solving conflicts. A clear delineation of roles and responsibilities will help ensure timely and efficient completion of the RWHAP Part A tasks. The role of PC/PB staff should also be included. The MOU must be consistent with bylaws and operating policies and procedures.

Term Limits

To ensure the PC/PB is reflective of the demographics of the population of individuals with HIV in the jurisdiction, HRSA HAB expects the PC/PB to establish term limits and membership rotations.

The intent of term limits is to ensure compliance with the RWHAP legislative requirement that requires the PC/PB to be reflective of the demographics of the population of individuals with HIV in the jurisdiction. Therefore, HRSA HAB expects the PC/PB to establish term limits and membership rotations for the required membership categories and unaligned persons with lived experience (i.e., persons receiving RWHAP Part A services and are not affiliated with funded RWHAP Part A providers as staff, board members, or consultants^{31,32}. HRSA expects that jurisdictions determine term limits and rotations that are in alignment with legislative and programmatic requirements, such as the integrated planning efforts, the comprehensive needs assessment, and the three-year period of performance. Jurisdictions should implement a predetermined period of time, during which outgoing members cannot reapply, to allow other community members the opportunity to serve. In addition,

²⁸ Section 2602(b)(5)(A) of the PHS Act.

²⁹ Section 2602(b)(7)(A) of the PHS Act.

³⁰ Section 2602(b)(5)(B) of the PHS Act.

³¹ Section 2602(b)(1) of the PHS Act.

³² 2602(b)(5)(C)(1) of the PHS Act.

jurisdictions can add additional members that include representation for long-term survivors to maintain input.

Grievance Procedures

The PC/PB must establish procedures to address grievances related to funding, including procedures for submitting grievances that cannot be resolved to binding arbitration.³³ There should be periodic local review of grievance procedures and their implementation to ensure legislative requirements are being met and grievances are being resolved in a timely and appropriate manner.

Open Meeting and Records

To carry out the array of planning tasks and duties required by HRSA HAB and the RWHAP legislation, the PC/PB meets regularly throughout the year in committees and as a whole. PC/PB meetings must be open to the public, with appropriate advance public notice provided for all meetings. This includes meetings of PC/PB committees and task forces as well as the general PC/PB meetings.

Records, reports, transcripts, minutes, agendas, or other documents that were made available to or prepared for or by the PC/PB shall be available for public inspection and copying at a single location. Detailed minutes of each meeting of the council shall be kept. The accuracy of all minutes shall be certified to by the PC/PB chair or co-chairs. PC/PB documents and information made available by the PC/PB should not include any disclosure of personal information, including disclosure of medical information, HIV status, or personnel matters.³⁴

Meeting times and locations should be announced on the PC/PB and/or health department website and on other appropriate online media. Both the minutes and other documents or materials made available to or prepared for the PC/PB should be available to the public within six weeks after the meeting date. It is important that detailed minutes are kept. Minutes need to show how the PC/PB arrived at funding decisions; this is especially true should a grievance be brought. A sound practice is to post approved PC/PB and committee minutes on the PC/PB website. If local, county, or state/territory regulations are more stringent than RWHAP requirements for open meetings, the PC/PB should follow the more stringent requirements.

Chair/Co-Chairs

The PC/PB needs to identify a chair or co-chairs. The legislation does not permit an employee of the RWHAP Part A recipient to serve solely as the chair.³⁵ An employee of the recipient may serve as a co-chair, provided the bylaws of the PC/PB permit or specify that arrangement. Bylaws should specify whether there is to be a chair or co-chairs and how they are selected. They may specify that the chair is to be appointed by the CEO or elected by the PC/PB from duly appointed members. Often, if a co-chair is appointed by the CEO or is an employee of the

³³ Section 2602(b)(6) of the PHS Act.

³⁴ Section 2602(b)(7)(B) of the PHS Act.

³⁵ Section 2602(b)(7)(A) of the PHS Act.

recipient, bylaws must require that the PC/PB elect the co-chair. An acknowledged best practice is to have bylaws require that one co-chair be a person with HIV. A number of jurisdictions have adopted this best practice with great success.

Orientation and Training

In order to meet RWHAP Part A requirements, HAB DMHAP expects the PC/PB to provide appropriate orientation and annual training and other support that enables members to be fully active participants and to fulfill their legislative responsibilities. At a minimum, annual membership training must occur, inclusive of client members. The PC/PB is responsible for providing updated training as needed to ensure that members understand their roles, responsibilities, and expectations for participation, how work is undertaken, and how formal decisions are made. Members also must understand policies/ground rules and have skills that make them comfortable when actively participating in meetings (e.g., understanding of Robert's Rules of Order). All PC/PB members need such training, but there may be additional needs for clients and for other members without prior experience in community planning processes.

III. Chapter 6. Technical Assistance, Links, and Resources

Integrated HIV Prevention and Care Plan Guidance:

<https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/integrated-hiv-dear-college-6-30-21.pdf>

National Monitoring Standards (NMS): <https://ryanwhite.hrsa.gov/grants/manage/recipient-resources>.

HRSA HAB Letter to RWHAP Part A Recipients:

- <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/transitional-grant-areas-planning-councils-moving-forward.pdf>
- <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/rwhap-part-letter-support-lived-experience.pdf>

Section IV. Clinical Quality Management

IV. Chapter 1. Overview

The complexity of HIV care and the RWHAP commitment to equal access to high-quality care for all people with HIV require systematic efforts to ensure all RWHAP-funded services are delivered efficiently and effectively. The recipient's CQM programs assesses whether RWHAP-funded providers are delivering high-quality HIV care and treatment and improve their systems of care, both of which are requirements of the RWHAP legislation.

RWHAP Part A CQM programs should use effective and proven quality management concepts and quality improvement methods in program development and implementation. By analyzing the data collected on outcomes of services, RWHAP Part A recipients can direct resources to services or expand models of care that have been proven effective in linking people with HIV to care, retaining them in care, and reaching and maintaining viral suppression (i.e., improving outcomes across the HIV care continuum).

HRSA HAB defines quality as “the degree to which a health or social service meets or exceeds established professional standards and user expectations.” RWHAP recipients determine, monitor, and improve the quality of their services by establishing a CQM program. RWHAP Parts A-D recipients are required to have a CQM program.

A CQM program is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction. To be effective, a CQM program requires:

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

IV. Chapter 2. Relevant Authorities

Section 2604(h)(5) of the PHS Act establishes requirements for RWHAP Part A CQM. Section 2604(h)(5)(A) requires:

“The chief elected official of an eligible area that receives a grant under this subpart shall provide for the establishment of a 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 Public Health Service 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.”

Additional language under Section 2604(h)(5)(B) of the PHS Act sets limits on the amount to be expended for CQM expenses:

(B) USE OF FUNDS-

- (i) IN GENERAL- From amounts received under a grant awarded under this subpart for a fiscal year, the chief elected official of an eligible area may use for activities associated with the clinical quality management program required in subparagraph (A) not to exceed the lesser of--*
- (I) 5 percent of amounts received under the grant; or*
- (II) \$3,000,000.*
- (ii) RELATION TO LIMITATION ON ADMINISTRATIVE EXPENSES- The costs of a clinical quality management program under subparagraph (A) may not be considered administrative expenses for purposes of the limitation established in paragraph (1).*

IV. Chapter 3. Components of a Clinical Quality Management Program

CQM is a systematic, structured, and continuous approach to meet or exceed established professional standards and user expectations. CQM is implemented by using tools and techniques to measure performance and improve processes. To implement a CQM program, recipients need to have the necessary infrastructure, performance measurement, and quality improvement (QI) components in place. HRSA RWHAP clarifies expectations for CQM programs in [PCN #15-02](#).

Infrastructure

CQM program infrastructure relates to the organizational structure and supports that allow the organization to measure performance and improve processes. Infrastructure includes leadership, a committee, dedicated staffing, dedicated resources, a written CQM plan, involvement of people with HIV and stakeholders, and CQM program evaluation. It is often difficult to sustain a successful CQM program if the infrastructure components are missing or weak.

While RWHAP Part A recipients are required to have a comprehensive CQM program that includes all three components (infrastructure, performance measures, and quality improvement), CQM programs will vary depending on the size and scope of the RWHAP. For example:

- RWHAP Part A recipients that fund many core medical and support services may require multiple staff to administer the CQM program, a large CQM committee that includes

multiple RWHAP Part representatives, and other stakeholders, and a client subcommittee that directly informs the larger CQM committee;

- RWHAP Part A recipients that fund only a few services may have a smaller CQM program but must still have adequate infrastructure to meet expectations outlined in [PCN #15-02](#); and
- A RWHAP Part A in a smaller TGA may have a single staff member who administers the CQM program and has other duties outside of the CQM program, a small CQM committee, and use other health department staff to ensure that all infrastructure is in place.

Please reference the infrastructure section of [PCN #15-02](#) for details.

Performance Measurement

Performance measurement is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes, or client satisfaction. Performance measures must be based on established professional standards, evidenced-based research, or client expectations, when possible. The analysis is completed by defining the data elements used to calculate the numerator and denominator for each performance measure. Additionally, HRSA HAB recommends that recipients stratify their performance measure data by subpopulation. Performance measures must be based on established professional standards and/or evidenced-based research, when possible. The stratified performance measure data can assist when analyzing the data to understand disparities and identify and focus quality improvement activities.

While performance measurement is a required component of a CQM program, performance measure portfolios can also vary depending on the size and scope of the RWHAP. Performance measures should reflect the RWHAP-funded service categories and local priorities. RWHAP Part A recipients in large, multijurisdictional EMAs may need a larger, more diverse set of performance measures in contrast to smaller RWHAP Part A recipients. RWHAPs should refer to [PCN #15-02](#) to determine the number of performance measures required for each funded service category. HRSA HAB has developed a <https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio> that RWHAP recipients may use. While HRSA HAB does not require recipients to use any specific measure, RWHAP recipients are encouraged to use the HAB core measures for funded service categories and to adopt other measures as needed for the program.

RWHAP Part A recipients may use performance measures at a system level or at a provider level. The core measures can be used at both the system level and provider level. For example, recipients are encouraged to use the HIV viral suppression performance measure to assess the entire RWHAP Part A HIV care system. Likewise, a RWHAP Part A recipient may have Medical Case Management (MCM) providers track and report the HIV viral suppression for the agency, thereby using the HIV viral suppression measure to assess performance at the provider level. Recipients can also choose to use HIV viral suppression to measure MCM services at a system level by aggregating data from all the MCM providers and assessing performance over time.

HRSA HAB encourages RWHAP Part A recipients to coordinate their performance measures with other RWHAP recipients in their service area. RWHAP Parts A-D recipients are required to have performance measures. Within a service area, recipients' coordination could have many benefits and reduce burden. The following are suggested areas for coordination:

- Alignment of performance measure definitions (numerators, denominators, and exclusions) for a service category can lead to analyzing data across the service area; and
- Agreement on performance measure reporting cycles (how often and when to report on performance measures) can reduce the frequency of reporting cycles for organizations funded by more than one RWHAP Part.

Quality Improvement

QI is a process of analyzing performance measure data and implementing activities to improve performance. QI is required regardless of the size and scope of the RWHAP Part A. Similar to performance measures, QI activities must focus on improving patient care, health outcomes, and/or client satisfaction. QI must be implemented using a defined methodology and in an organized systematic fashion. The most common QI methodologies are the Model for Improvement and Lean Six Sigma, although other methodologies exist. At a minimum, RWHAP Part A recipients must implement at least one QI activity at any given time for at least one service category and document the QI activities.

IV. Chapter 4. Subrecipient Involvement

RWHAP Part A recipients must include all subrecipients in the recipient's CQM program. Recipients are to identify the specific CQM program activities for their subrecipients. Subrecipient activities often include participating on the recipient's CQM committee and training, providing performance measure data, and implementing QI activities. HRSA HAB encourages recipients to codify subrecipient CQM activities in RFPs and contracts. However, the contribution of subrecipients to the recipient's CQM program will vary depending on the services provided and the resources available. For example, given their key role in HIV care, outpatient ambulatory health services providers should have an active role in the recipient's CQM program, such as participating in the CQM committee, reporting performance measure data, and contributing to QI projects.

In contrast, for example, medical transportation providers may track and report the number of clients transported in a given timeframe but would not have client-level data on patient care or health outcomes. Therefore, the medical transportation provider would not be able to assess the impact on health outcomes. Recipients could combine client-level utilization data and clinical data to assess a retention in care performance measure.

It is important to remember that the RWHAP legislative requirements for CQM apply to both the clinical and support services funded and subrecipients who provide such services. As such, RWHAP Part A recipients are expected to incorporate quality-related requirements into RFPs and EMA/TGA subawards.

IV. Chapter 5. HRSA HAB Monitoring of Clinical Quality Management

HRSA HAB monitors RWHAP Part A recipients' CQM programs to ensure that the legislative and programmatic CQM requirements are met. Monitoring occurs through several mechanisms, including the following:

- Discussion of CQM programs during monthly monitoring calls;
- Review of submitted CQM plans and information on recipient CQM programs that may be requested in annual NOFOs and/or progress reports; and
- Review of CQM programs during comprehensive site visits.

EMAs/TGAs must sign assurances in their RWHAP Part A applications or NCCs attesting that appropriate CQM programs are in place.

If concerns are identified during routine monitoring, the HAB DMHAP PO may engage a CQM subject matter expert to work with recipients in addressing the concern. Recipients should contact their HAB DMHAP PO with any questions they may have about CQM programs or plans.

IV. Chapter 6. Additional Clinical Quality Management Concepts

Model for Improvement

The Model for Improvement is a simple yet powerful tool for accelerating improvement. This model has been used successfully by hundreds of health care organizations in many countries to improve many different health care processes and outcomes. The model has two parts:

- 1) Answer three fundamental questions, which can be addressed in any order:
 - a) What are we trying to accomplish?
 - b) How will we know that a change is an improvement?
 - c) What change can we make that will result in an improvement?
- 2) Use the Plan-Do-Study-Act (PDSA) cycle to test changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.
 - a) Plan – Identify problems (including their components—not just the big picture) and then plan strategies/tests that might result in improvements.
 - b) Do – Use strategies that are designed to address problems.
 - c) Study – Collect and analyze data to see if strategies have resulted in improvements.
 - d) Act – If the strategies are effective, make them an ongoing activity. If they are not effective, return to the Plan stage. Use collected data to identify new ways to address problems.

Benchmarking and Best Practices

Benchmarking is the process of comparing one's performance to that of a higher performing organization of similar characteristics, determining the best practices that have led to the higher performance, and implementing the best practices. The goal is to make changes to a process that will result in higher performance. Some organizations use their own data as a baseline benchmark against which to compare future performance.

Clinical Practice Guidelines

Clinical practice guidelines generally are written by a respected authority and are based on the most recently available state of knowledge, clinical research, and expert opinion. The purpose of guidelines is to provide recommendations on how to screen, treat, and provide care and services. The Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents and a variety of continuously updated guidelines in HIV care and treatment can be found at <https://clinicalinfo.hiv.gov/en/guidelines>. Guidelines are often the basis for developing performance measures and standards of care.

Implementation Science

Implementation science has emerged as an essential field for HIV research and programming, promising to maximize the impact of effective intervention strategies and ensure their integration into practice, program, and policy to improve patient and public health outcomes. HRSA HAB has developed an implementation science approach that is shaping its work to achieve optimal outcomes for people with HIV along the HIV care continuum. While HRSA has played a pivotal role in the implementation of effective intervention strategies for people with HIV since the beginning of the HIV epidemic, implementation science frameworks and approaches have created new opportunities to maximize the impact of the RWHAP. The HRSA HAB Implementation Science Framework, or HAB is involves two core components, the first of which is rapid implementation – a systematic process for identifying intervention strategies with demonstrated effectiveness at improving outcomes for people with HIV and disseminating them through accessible, multimedia toolkits for rapid replication. The second component is a novel implementation science evaluation framework that assesses not only those intervention strategies that demonstrate effectiveness at improving client outcomes, but also the specific implementation strategies and broader contextual factors that promote their uptake and integration into routine practice. By scaling up effective intervention strategies to decrease morbidity and mortality and improve health outcomes along the HIV care continuum for people with HIV, implementation science is advancing the work of HRSA HAB and the RWHAP, ultimately getting closer to ending the HIV epidemic.³⁶

³⁶ Psihopaidas, et al., 2020. Implementation Science and the Health Resources and Services Administration's Ryan White HIV/AIDS Program's Work Towards Ending the HIV Epidemic in the United States. Available at <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003128>. Accessed June 24, 2022.

Service Standards

Service standards, which are sometimes referred to as standards of care, are principles and practices for the delivery of health and social services that are accepted by recognized authorities and used widely. Service standards for HIV care are based on specific research (when available) and the collective opinion of experts. Service standards are often informed by guidelines, clinical research, and patient experiences.

RWHAP service standards outline the elements and expectations a RWHAP service provider follows when implementing a specific service category to ensure that all service providers offer the same fundamental components of the given service category across the service area. They establish the minimal level of service or care that a RWHAP Part A-funded agency or provider may offer within a jurisdiction.

IV. Chapter 7. CQM Technical Assistance, Links, and Resources

The following links provide additional information on CQM, the RWHAP policies, and other related information relevant to the development and implementation of a CQM program.

HAB Website: <https://ryanwhite.hrsa.gov>. For links to information and resources on [Clinical Care Guidelines and Resources](#), [Policy Notices](#), [HAB Performance Measure Portfolio](#), and [Quality of Care](#).

HAB Performance Measures - List of Performance Measures and Frequently Asked Questions (FAQ): <https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio>.

HIV Quality Measures Module: The HIV Quality Measures (HIVQM) Module is an online data system for use by all RWHAP recipients called the HIVQM Module. The HIVQM Module's purpose is to help recipients set goals and monitor performance measures as well as quality improvement projects to better support CQM, performance measurement, service delivery, and client monitoring at both the recipient and client level:
<https://ryanwhite.hrsa.gov/grants/quality-of-care>.

RWHAP Clinical Quality Management Listserv: Online user forum for RWHAP CQM staff to ask questions, seek advice, and share resources with others:
<https://public.govdelivery.com/accounts/USHHSHRSA/signup/29907>.

Section V. Grants Administration

V. Chapter 1. Overview

RWHAP Part A recipients are responsible for the administration of the RWHAP Part A grant, regardless of whether the administration of the program is outsourced to an entity acting on behalf of the recipient, inclusive of the formula, supplemental, and MAI funding. The RWHAP legislation, UAR, Cost Principles, and Audit Requirements for HHS Awards, NoAs, and HRSA HAB PCNs and Program Letters contain federal rules and guidance governing grants management for the RWHAP Part A. RWHAP Part A recipients must be familiar with these documents to ensure compliance with these grant requirements and policies.

This section provides a high-level overview of federal grants management requirements and identifies useful tools that can assist with meeting these requirements and successfully managing a RWHAP Part A grant award.

V. Chapter 2. Role of HRSA HAB and the Office of Financial Assistance Management

HAB DMHAP monitors the RWHAP Part A, and the HAB DMHAP PO is the staff person responsible for monitoring the programmatic and technical aspects the RWHAP Part A awards. HAB DMHAP POs work with recipients to:

- Provide programmatic TA;
- Monitor post-award activities of project/program performance, including review of progress reports and making site visits; and
- Address business management and other non-programmatic aspects of the RWHAP Part A award in collaboration with the HRSA Grants Management Specialist (GMS).

HRSA's OFAM ensures the financial integrity of HRSA's grant programs and oversees HRSA grant activities to ensure they are managed in an efficient and effective manner. The OFAM Division of Grants Management Operations (DGMO) handles the business management aspects of grant review, negotiation, award, and administration by:

- Receiving all grant applications;
- Monitoring the objective review process;
- Performing cost analysis prior to grant award and approving changes in budgets, as necessary;
- Providing business management consultation and TA;
- Signing and issuing grant awards, amendments to awards, close out of grants, and notices of suspension and termination;
- Receiving and responding to all correspondence related to business activities;
- Receiving all documentation submitted for compliance with the terms and conditions of the grant award (financial reports, revised budgets, and other related conditions of award);
- Maintaining the official grant file;
- Conducting continuous surveillance of the financial and management aspects of grants; and

- Resolving audit findings.

Each recipient's award has a designated HRSA GMS to help address grant management issues and/or questions that may arise. The NoA includes contact information for the designated HRSA GMS.

V. Chapter 3. Relevant Authorities

Recipients should be familiar with and have a clear understanding of relevant authorities for RWHAP Part A to ensure proper administration and monitoring of the award. The following are the relevant authorities that are applicable to the RWHAP Part A federal award.

Legislation

The parts and sections of the legislation that apply to the RWHAP Part A are: Part A—Emergency Relief for Areas with Substantial Need for Services of Title XXVI of the PHS Act, Sections 2601 through 2610; Part E—General Provisions of Title XXVI of the PHS Act, Sections 2681 through 2689; and Part F—Demonstration and Training, Subpart III—Minority AIDS Initiative of Title XXVI of the PHS Act, Section 2693. See <https://ryanwhite.hrsa.gov/about/legislation>.

UAR

The UAR, which is codified at [2 CFR Part 200](#) addresses many issues, including:

- Standards for fiscal management systems, including payments, program income, revision of budget and program plans, and non-federal audits;
- Property standards, including the purpose of insurance coverage, equipment, supplies, and other expendable property;
- Procurement standards, including recipient responsibilities, codes of conduct, competition, procurement procedures, cost and price analysis, and procurement records;
- Reports and records, including monitoring and reporting program performance reports, financial reports, and retention and access requirements;
- Termination and enforcement;
- Closeout procedures;
- Cost principles; and
- Audits.

On August 13, 2020, the OMB published final guidance in the Federal Register, revising sections of the OMB UAR, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance), located at 2 CFR Part 200. OMB revised the Uniform Guidance again on April 22, 2024, effective October 1, 2024. On October 2, 2024, HHS [published an interim final rule \(IFR\)](#) outlining a phased plan for adopting 2 CFR part 200. In the IFR, HHS announced they adopted the changes to the eight thresholds increases on October 1, 2024, and will adopt the rest of 2 CFR part 200 on October 1, 2025, except for twelve HHS-specific provisions that will move to 2

CFR part 300

Recipients who accept the RWHAP Part A NoA by drawing down funds agree to adhere to the current legislative mandates, including those found in the annual appropriations acts. Recipients should stay abreast of any updates to the appropriation acts and can do so by looking for grants policy bulletins posted on the HRSA.gov website, on the Manage Your Grant – Policy, Regulation, & Guidance page.

HHS Grants Policy Statement

The HHS GPS makes available in a single document the general terms and conditions of HHS discretionary grant and cooperative agreement awards. These general terms and conditions are common across all HHS Operating Divisions (OPDIVs) and apply as indicated in the HHS GPS, unless there are legislative, regulatory, or award-specific requirements to the contrary (as specified in individual NoAs). The HHS awarding offices are components of the OPDIVs and staff divisions that have grant-awarding authority. See

<https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>

Notices of Funding Opportunity

HRSA staff develop a NOFO for each grant or cooperative agreement program. The NOFO includes the purpose of the program, amount of funding available, period of performance, eligible applicants, content and form of application submission, and other important information. HRSA NOFOs are available on the HRSA website and are posted to [Grants.gov](https://www.grants.gov). An applicant should carefully review the NOFO prior to application submission and be aware of all requirements and restrictions applicable to the receipt of federal funding. See

<https://www.hrsa.gov/grants/fundingopportunities/default.aspx>, and

<https://www.grants.gov/web/grants>.

Notice of Award

An NoA is issued through the HRSA Electronic Handbooks (EHBs) for each federal grant award. The NoA references all the legislative and programmatic requirements of the grant or cooperative agreement, including grant or cooperative agreement-specific terms, program-specific terms, standard terms, conditions of award, and reporting requirements. A recipient indicates acceptance of an award and its associated terms and reporting requirements by drawing or requesting funds from the Payment Management System (PMS). Failure to comply with any terms, conditions, and/or reporting requirements by the corresponding due date, where applicable, may result in the suspension of the recipient's ability to drawdown funds, the disallowance of funds, or both.

In addition, the NoA includes a special remarks section that contains information such as expenditure limitations. There is also a contact section with names, addresses, and telephone numbers of persons to contact regarding grant management and/or programmatic issues. See <https://www.hrsa.gov/sites/default/files/grants/manage/awardmanagement/notice/noticeofaward.pdf>.

HRSA HAB Program-Specific Policies, Policy Clarification Notices, Policy Notices, and Program Letters

HRSA HAB develops notices and letters to provide additional guidance to recipients on understanding, adhering to, and implementing RWHAP legislative requirements. See <https://ryanwhite.hrsa.gov/grants/policy-notices> and <https://ryanwhite.hrsa.gov/grants/program-letters>.

National Monitoring Standards

The National Monitoring Standards (NMS) are a resource to support recipients and subrecipients in meeting federal requirements for program and fiscal management, monitoring, reporting, and oversight of the RWHAP Parts A and B, and to improve program efficiency and responsiveness. See Section VI, Chapter 3 for more information. See <https://ryanwhite.hrsa.gov/grants/manage/recipient-resources>.

V. Chapter 4. Key Legislative Requirements

In order to ensure compliance, recipients should be familiar with and have a clear understanding of the following key legislative requirements.

Payor of Last Resort

Section 2605(a)(6) of the PHS Act requires:

that funds received under a grant awarded under this subpart will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service—

(A) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program (except for a program administered by or providing the services of the Indian Health Service); or

(B) by an entity that provides health services on a prepaid basis.

[PCN #21-02](#) states that recipients and subrecipients are to establish, implement, and monitor policies and procedures to determine client eligibility based on HIV status, income, and residency. Once a client is eligible to receive RWHAP services, the RWHAP is considered payor of last resort. RWHAP recipients and subrecipients must ensure that reasonable efforts are made to use non-RWHAP resources whenever possible, including establishing, implementing, and monitoring policies and procedures to identify all possible payors to extend RWHAP funds. Recipients and subrecipients must document the steps taken during their pursuit of enrollment in health care coverage for all clients. To ensure compliance with this requirement, the RWHAP Part A recipient and any subrecipient must ensure that other available payors are billed appropriately. They also must assess individual client eligibility for other funding sources and

assist clients to vigorously pursue these other funding sources. Recipients are permitted and encouraged to continue providing services funded through RWHAP to a client who remains unenrolled in other health care coverage, as long as there is rigorous documentation that such coverage was vigorously pursued. Periodic checks should be documented to identify any changes to clients' healthcare coverage. Changes to client's healthcare coverage may affect the payor of last resort. In addition, RWHAP funds may be used to fill coverage gaps, including services that are only partially covered for individuals who are either underinsured or uninsured in order to maintain access to care and services as allowable and defined by the RWHAP.

The RWHAP is the payor of last resort, with the exception of people with HIV who are eligible to receive benefits or services through the Indian Health Service. Individuals that are eligible for RWHAP services may choose to access the RWHAP for their care, rather than accessing services from the Indian Health Service or the Department of Veterans Affairs. (See [PCN #16-01](#), Clarification of the Ryan White HIV/AIDS Program (RWHAP) Policy on Services Provided to Veterans.)

Maintenance of Effort

RWHAP Part A recipients are to maintain, as a condition of award, EMA/TGA expenditures for HIV-related core medical and support services at a level equal to the fiscal year preceding the fiscal year for which the recipient is applying to receive an RWHAP Part A grant. Core medical services and support services are defined in Sections 2604(c)(3) and (d) of the PHS Act and [PCN #16-02](#), Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds.

RWHAP Part A recipients must document that they will meet the Maintenance of Effort (MOE) requirement annually. Recipients attest to their compliance with this requirement by signing agreements and compliance assurances in either the RWHAP Part A competitive application or NCC Progress Report.

Section 2605(a)(1)(B) of the PHS Act requires:

that the political subdivisions within the eligible area will maintain the level of expenditures by such political subdivisions for HIV-related services as described in section 2604(b)(1) at a level that is equal to the level of such expenditures by such political subdivisions for the preceding fiscal year.

Maintenance of Effort Documentation Requirements

To demonstrate compliance with the MOE provision, EMAs/TGAs must maintain adequate systems for consistently tracking and reporting on HIV-related expenditure data for core medical and support services from year-to-year. The system must define the methodology used, be written and auditable, and ensure that federal funds do not supplant EMA/TGA spending but instead expand and enhance such activities.

In order to receive an RWHAP Part A award, EMAs/TGAs must comply with MOE requirements, which include submission of the following documents with the RWHAP Part A application and NCC Progress Report:

- Signed assurance that MOE has been maintained;
- Identification of the baseline aggregate non-federal EMA/TGA political subdivision expenditures for HIV-related core medical and support services for the recipient's most recently completed fiscal year prior to the new application deadline;
- Estimate for the next fiscal year; and
- Description of the process, methodology, and elements used to determine the amount of expenditures in the MOE calculations.

Maintenance of Effort Monitoring and Compliance

Recipients are required to maintain documentation regarding MOE and provide the documentation upon request. During a comprehensive site visit (CSV) or at any time during the grant period of performance, HAB can request to review the following documents:

- Budget elements that document the contributions of the EMA/TGA;
- Description of the tracking/accounting system that documents the city/county/municipality's contribution to core medical services and support services;
- Recipient budget for city/county/municipal contributions; and
- The actual tracking/accounting documentation of contributions.

Administrative Caps and Salary Rate Limitations

The RWHAP legislation puts limits on administrative costs. [PCN #15-01](#), Treatment of Costs under the 10 Percent Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, and C, clarifies HRSA guidelines for the treatment of costs under the recipient administrative cost cap.

CEOs (or their designees) are required to sign program assurances related to these legislative requirements with the grant application or NCC Progress Report to HRSA for funding (SF-424B, Program Assurances). Compliance with program assurances and legal requirements are subject to audit by such entities as the HHS Office of Inspector General (OIG) and the Government Accountability Office (GAO).

To assure compliance with required caps, HRSA strongly recommends that recipients require subrecipients to submit a budget and invoices that clearly identify administrative costs. Recipients are responsible for tracking subrecipient aggregate administrative costs.

Salary Rate Limitation

The Annual Appropriations Act provides a salary rate limitation. The law restricts the amount of salary that may be paid to an individual under an HHS grant, cooperative agreement, or applicable contract to a rate no greater than Executive Level II of the Federal Executive Pay Scale. Executive Level Pay Tables are available at <https://www.opm.gov/policy-data->

[oversight/pay-leave/salaries-wages/](#). Recipients, subrecipients, and contractors must ensure that salaries paid with RWHAP grant funds do not exceed the current rate.

RWHAP program income cannot be used to pay a salary rate in excess of the salary limitation. For additional information and examples of how to apply the salary limitation, see the [HRSA SF-424 Application Guide](#).

Administrative Caps

Section 2604(h) of the PHS Act defines administrative activities for RWHAP Part A recipients and subrecipients and limits the amount RWHAP Part A recipients can spend on such costs. Administrative costs are capped at 10 percent and include indirect costs. Subrecipient administrative costs are capped at 10 percent in the aggregate.

Per the RWHAP legislation, administrative costs relate to oversight and management of RWHAP funds and include items such as contracting, accounting, data reporting, PC/PB support, quality assurance, and subrecipient monitoring. If an RWHAP Part A recipient has a subaward or contract with a lead agency or fiduciary agent to provide RWHAP Part A program or fiscal management on behalf of the recipient, the administration costs of that subaward or contract counts toward the 10 percent recipient administrative cap. Any costs associated with direct service delivery by the recipient or through subawards do not count toward the recipient administrative cap.

[PCN #15-01](#), Treatment of Costs under the 10 percent Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D, provides additional guidance on what costs must be charged to administration and where there is flexibility on charging costs toward direct service.

A recipient must determine the amounts necessary to cover its administrative and program support activities. In addition, PC/PB support costs are considered part of the recipient administrative budget and together are capped at 10 percent. The recipient also must ensure adequate funding for PC/PB-mandated functions within the administrative line item. PC support should cover reasonable and necessary costs associated with carrying out legislatively mandated functions.

Aggregate Administrative Cap for RWHAP Part A Service Delivery

RWHAP Part A recipients must limit the administrative costs of subrecipients that provide HIV services to 10 percent in the aggregate. The 10 percent aggregate administrative cap applies to all subrecipients providing services, whether funded directly by the recipient or funded through an entity under contract to provide administrative and/or fiscal management. Recipients may choose to allow individual subrecipients to exceed 10 percent administrative costs of their individual award, as long as the aggregate of all subrecipients does not exceed 10 percent of HIV services expenditures.

If a recipient issues a subaward or contract to an entity to provide both RWHAP Part A management on behalf of the recipient and core medical or support services, then:

- 1) The administrative costs associated with RWHAP Part A management count toward the 10 percent recipient administrative cap; and
- 2) The administrative costs associated with the provision of core medical or support services count toward the 10 percent subrecipient aggregate administrative cap.

Documentation of Compliance with Caps

As part of the competitive application or NCC Progress Report, RWHAP Part A recipients are required to submit a Budget Information for Non-Construction Programs Form (SF-424A), categorical budgets, and budget narrative justifications to HRSA for approval by program cost category — administration, CQM, and HIV services. These budgets must clearly specify recipient administration, CQM, and HIV services costs. The HAB DMHAP PO and HRSA GMS review recipient budgets and determine whether the recipient's costs fall within the legislative limits.

At the end of the budget year, the recipient submits an Expenditure Report to HRSA HAB, which the HAB DMHAP PO reviews to verify that the recipient's administrative expenses do not exceed the 10 percent administrative cap. In addition, the recipient will attest that subrecipient administrative expenditures in the aggregate do not exceed 10 percent.

Administrative Cost Cap Scenarios

Allowable administrative activities are broadly defined in the legislation³⁷ and further detailed in [PCN #15-01](#), as well as in [PCN 15-02](#) as they relate to CQM programs. Recipients should use consistent guidelines to assign particular costs to local funds or to federal awards. However, requirements specific to RWHAP Part A, as defined in this chapter and as outlined in HAB program guidance, must be followed.

1) Recipients

If a recipient makes RWHAP Part A funds available to one or more contracted entities that perform functions on behalf of the recipient, then the costs of these activities count against the recipient's administrative cost cap. A RWHAP Part A recipient's city health department might make funds available to the health department of an outlying county (possibly in another state for jurisdictions whose boundaries cross state lines) to fund service providers in that county. The costs for that particular county to develop RFPs for proposals, disburse subawards, develop reimbursement and accounting systems, monitor subrecipients, etc., count against the recipient's 10 percent administrative cost cap.

If the recipient or a contracted entity performs functions on behalf of the recipient and is also delivering a RWHAP-funded service, the costs of that service and any administrative activities associated with providing the services do not count against the recipient's 10 percent administrative cap. The administrative activities associated with the provision of services, however, count against the 10 percent aggregate administrative cap imposed on subrecipients receiving RWHAP funds.

³⁷ Section 2604(h)(3)-(4) of the PHS Act.

2) Unit Costs/Fees

For those situations in which a unit cost system is used to pay a subrecipient, the unit cost must be broken down so that administrative and direct service cost per service can be distinguished. The indirect cost of the unit cost is subject to the 10 percent aggregate administrative cap. A unit cost must be reconciled at the end of the year using paid invoices and actual service units reported. If the payment made is determined to be unreasonable, recipients must re-negotiate next year's payment.

Core Medical Services Requirement

Section 2604(c)(1) of the PHS Act requires recipients to expend 75 percent of the grant funds, minus the amount reserved for administration and CQM activities, on HIV core medical services (i.e., the 75 percent core medical services requirement). In addition to HIV core medical services, recipients may fund key support services needed to achieve medical outcomes. Section 2604(d)(1) of the PHS Act defines support services as those “that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).”

Waiver of Core Medical Services Requirement

Section 2604(c)(2) of the PHS Act allows recipients to request a waiver of the 75 percent core medical services requirement if the recipient can demonstrate the availability of core medical services for all identified and eligible people with HIV in the service area, and if there is not an ADAP waiting list in the state/territory. In addition, per PCN 21-01, a public process to obtain input on the waiver request must have occurred. This process must seek input from impacted communities, including clients and RWHAP-funded core medical services providers, on the availability of core medical services and the decision to request the waiver. The public process may be a part of the same one used to seek input on community needs as part of the annual priority setting and resource allocation, comprehensive planning, SCSN, public planning, and/or needs assessment processes. Applicants may submit a one-page HRSA RWHAP Core Medical Services Waiver Request Attestation Form to HRSA HAB, attesting that the underlying statutory and policy requirements for requesting a core medical services waiver have been met with their grant application or NCC Progress Report. For more information on the Core Medical Services Waiver, refer to [PCN # 21-01](#), Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement.

Clinical Quality Management Program Costs

CQM costs are addressed legislatively under Section 2604(h) of the PHS Act. The CEO may use funds for activities associated with the CQM program not to exceed 5 percent of the grant award or \$3,000,000, whichever is less. CQM costs are not included in the 10 percent cap for administrative costs.

CQM costs may include, but are not limited to, the following:

- Management of and planning for the CQM program (e.g., convening a CQM committee, working with first- or second-line subrecipients, implementing quality improvement projects, etc.);
- Data management and extraction for CQM purposes (e.g., performance measure data collection, aggregation, analysis, and reporting);
- CQM monitoring site visits (if the purpose for the site visit is to assess or monitor the CQM program);
- Gathering information and data on client experience related to performance management and quality improvement (e.g., surveys, focus groups, client interviews, etc., used for CQM); and
- Performance measurement prioritization and alignment with other RWHAP Parts in the service area.

Though quality assurance activities (developing service standards, performing site visits, chart reviews, etc.) are aimed at ensuring compliance with minimum standards, quality assurance activities cannot be charged to the CQM budget. Those costs must be charged to administration. If costs are administrative in nature or cannot be tied to improving patient satisfaction, health outcomes, or patient care, the costs must be charged to administration.

See Section III and Clinical Quality Management [PCN 15-02](#), for more information on CQM.

Women, Infants, Children, and Youth Expenditures

Section 2604(f)(1) of the PHS Act requires RWHAP Part A recipients to use a proportionate amount of their grant dollars to provide services to women, infants, children, and youth (WICY) with HIV.

The WICY provision requires the use of funds for such designated populations within the overall RWHAP Part A program, but it does not require PCs to create a special priority for services to these populations. A waiver to WICY requirement provision can be granted when EMAs/TGAs can demonstrate that the needs of each population or combination of these populations is being met through other programs, such as Medicaid, the Children’s Health Insurance Program (CHIP), or other federal or state/territory programs.

Recipients must submit a WICY expenditures report or waiver request with the APR. Recipients can use the RWHAP Part A WICY report template provided by HRSA HAB with the Annual Progress Report (APR) instructions to report expenditures.

Imposition of Charges

Imposition of charges is a term used to describe all activities, policies, and procedures related to assessing RWHAP patient charges as outlined by legislation. In accordance with Section 2605(e) of the PHS Act, RWHAP Part A recipients and subrecipients must impose a charge for billable services provided to RWHAP-eligible clients with individual annual gross incomes above 100

percent of the federal poverty level (FPL). Imposition of charges is based on income of the individual, not on total household income or family income. No charges are to be imposed on clients with individual annual gross incomes at or below 100 percent of the FPL.³⁸ The legislation requires imposing a charge for clients whose incomes are greater than the FPL, and it sets limits for annual charges. Further, there is a prohibition on the denial of services due to a client's inability to pay.

The recipient and its subrecipients are required to have a publicly available schedule of charges. A schedule of charges are fees imposed on the patient for services based on the individual's annual gross income. RWHAP clients with income at or below 100 percent of the FPL may not be assessed a charge. However, clients with income above 100 percent of the FPL must be assessed a charge. The charge may take the form of a flat rate or a varying rate (e.g., sliding fee scale or nominal charge). A schedule of charges applies to uninsured patients only, as insurance companies are billed the full price (fee schedule) for insured RWHAP clients. For those recipients with no billable services, a policy must be in place to monitor subrecipients' implementation of imposition of charges requirements.

The RWHAP legislation establishes limitations on amounts of annual aggregate charges (i.e., caps on charges) in a calendar year for RWHAP services imposed on clients, which are based on the percent of a client's annual individual gross income, as follows:

- Five percent for clients with individual annual gross incomes between 101 percent and 200 percent of the FPL;
- Seven percent for clients with individual annual gross incomes between 201 percent and 300 percent of the FPL; and
- 10 percent for clients with individual annual gross incomes greater than 300 percent of the FPL.

In addition, the legislation explicitly defines and includes as part of "cumulative charges" the charges for HIV-related services performed by providers other than the recipient or its subrecipients.³⁹ That is, the cap on charges to clients applies to any charges made to clients for all HIV services performed by RWHAP providers as well as any out-of-pocket costs, such as enrollment fees, premiums, deductibles, cost sharing, co-payments, and coinsurance. Unlike the schedule of charges, cap on charges applies to all RWHAP patients, regardless of income or healthcare coverage.

Recipients and subrecipients must have a written policy for imposition of charges. The policy should include:

- Publicly available schedule of charges that is based on a nominal fee or a varying rate (e.g., sliding fee scale). Client placement on the schedule of charges must be based on the **client's individual annual gross income**, although client eligibility for RWHAP services may be based on family income, if that is the policy of the recipient. Schedule of charges

³⁸ Section 2605(e)(1)(A) of the PHS Act.

³⁹ Section 2605(e)(3) of the PHS Act.

indicates clients with individual annual gross incomes less than or equal to 100 percent of the FPL are not charged for RWHAP services;

- Process to capture documentation of the RWHAP patient's annual gross income needed to determine placement on the schedule of charges and annual cap on charges;
- Process to track imposed charge by the provider and payments received from clients, including out-of-pockets costs;
- Process to assess, document, and track charges imposed by other RWHAP providers toward a client's cap on charges; and
- Process to ensure charges for RWHAP services cease when a client has reached the annual cap on charges based on their annual individual gross income.

The policy must align with all RWHAP Part A requirements. HRSA HAB considers it a best practice to align such policies within an RWHAP Part A jurisdiction across the RWHAP Parts, if possible. Staff should be familiar with and trained on the policy to ensure consistency of implementation. Recipients and subrecipients should incorporate the policy in all provider agreements (e.g., subawards, contracts, fee for service agreements, and other legal agreements). Recipients and subrecipients should develop materials about the imposition of charges policy for clients including tools (e.g., worksheets, business reply envelopes, etc.) to inform them of their role in the imposition of charges (e.g., tracking charges across all RWHAP providers and other out-of-pocket costs).

V. Chapter 5. Program Income

Program Income

Program income is the gross income earned by a recipient or a subrecipient under a grant that was directly generated by activities supported by the grant or earned as a result of the award during the period of performance, except as provided in [§ 200.307\(c\)](#). (See “Period of Performance.”) Program income includes but is not limited to income from fees for services performed, the use or rental of real or personal property acquired under federal awards, the sale of commodities or items fabricated under a federal award, license fees and royalties on patents and copyrights, and principal and interest on loans made with federal award funds. Interest earned on advances of federal funds is not program income. Except as otherwise provided in federal statutes, regulations, or the terms and conditions of the federal award, program income does not include rebates, credits, discounts, and interest earned on any of them.⁴⁰ See also [§ § 200.307](#), [200.407](#) and [35 U.S.C. 200-212](#) (applies to inventions made under federal awards).⁴¹

Sources of program income for RWHAP Part A recipients and their subrecipients are the charges to RWHAP Part A clients or to insurance companies for services performed. Direct payments include charges imposed by recipients and subrecipients for RWHAP Part A services as required under Section 2605(e) of the PHS Act, such as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges. When the RWHAP Part A grant is the federal award that makes a recipient eligible as a 340B Drug Pricing Program covered entity, and the recipient purchases pharmaceuticals via 340B pricing, the program income should be attributed to the RWHAP Part A grant. When a recipient is 340B-eligible and purchases pharmaceuticals via 340B pricing under multiple awards, the recipient must use a reasonable allocation method for the attribution of costs and program income and be able to document the methodology used.

Lastly, no program income is generated when the RWHAP recipient is paying the subrecipient the cost of each covered service provided to eligible uninsured clients and there are no payments or reimbursements for the provision of that service from third-party payors (Medicare, Medicaid, or private health insurance).

Expenditure

Under the UAR and [PCN #15-03](#), to the extent available, recipients and subrecipients must disburse funds available from program income, rebates, refunds, contract settlements, audit recoveries, and interest earned on such funds before requesting additional cash payments.⁴² Recipients and subrecipients should strive to proactively secure and estimate the extent to which program income will be accrued to effectively determine the need for RWHAP funds and their allocation and utilization during the current period of performance.

⁴⁰ <https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-03-program-income.pdf>

⁴¹ Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 2 CFR § 200.1.

⁴² Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 2 CFR § 200.305(b)(5).

2 CFR § 200.305(b)(5) requires that, to the extent available, recipients and subrecipients must disburse funds available from program income and interest earned on such funds before requesting additional cash payments through the PMS. As such, RWHAP Part A recipients must spend program income received prior to drawing down grant funds. As noted in 2 CFR § 200.1, “expenditures” means charges made by the RWHAP recipient. For recipients on an *accrual basis* of accounting, the expenditure is recognized at the time the cost is incurred (i.e., when the contract is awarded). If program income funds are obligated for a contract awarded during the project period, the expenditure has been recognized (i.e., program income funds have been spent). Neither the contract’s period of performance nor when the funds are actually paid (i.e., liquidated) is a factor. For recipients on a *cash basis* of accounting, the expenditure is recognized at the time the payment is remitted. The expenditure is not recognized until such time funds are actually paid (i.e., liquidated). Program income received at the end of the budget period must be expended by the recipient prior to the expenditure of new RWHAP Part A funds awarded in the subsequent budget period.

Program income funds are not subject to the RWHAP recipient cost caps for administration and CQM costs or the 75 percent core medical services requirement, but the salary rate limitation still applies. (See Section V, Chapter 4, Costs and Caps for more information.) Use of program income for allowable costs (e.g., purchasing a vehicle) does not require prior approval, even if such use of federal grant funds would require prior approval.

Tracking and Reporting

Recipients and subrecipients are required to track and account for all program income in accordance with 2 CFR § 200.302(b)(3). Recipients must report their program income (but not that of their subrecipients) on the final FFR. Supporting documentation is not required with the FFR but may be requested during an audit or a site visit.

Likewise, recipients must require that their subrecipients report and utilize program income as required above. Recipients are responsible for ensuring that subrecipients have systems in place to account for program income and for monitoring to ensure that subrecipients are tracking and using program income consistent with grant requirements.

[PCN #15-03](#) gives guidance on the required documentation and tracking of program income. For RWHAP Part A, program income is considered additive in nature and is to be used for the purposes and under the conditions of the award and may only be used for allowable RWHAP costs, including to provide eligible services to eligible clients. To meet the requirements of [PCN #15-03](#), recipients should require financial and performance reports necessary to ensure that the subaward, and any income generated by it, is used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the award. Subrecipients should retain program income for additive use within their own programs. Recipients should not report program income generated by subrecipients on the FFR.

For more information on reporting recipient program income on the final FFR, see Section VI, Reporting Requirements, Chapter 3.

V. Chapter 6. Unobligated Balances and Carryover of Funds

Section 2603(c) of the PHS Act and the UAR address the impact of unobligated balances (UOBs) on future funding. An EMA/TGA with an UOB greater than 5 percent of the formula award is subject to financial penalty. HRSA HAB [PCN #12-02](#) explains the UOB requirements and potential penalties imposed on recipients that do not comply with the requirements contained in Section 2603(c) of the PHS Act.

RWHAP Part A recipients that have a UOB greater than 5 percent of the RWHAP Part A formula award are subject to two penalties:

- 1) A reduction in the RWHAP Part A formula award of the future year award equal to the amount of UOB minus any amount approved for carryover; and
- 2) Ineligibility to receive RWHAP Part A supplemental funds in the future year.

Estimated Unobligated Balance and Estimated Carryover Request

RWHAP Part A recipients are required to submit a completed RWHAP Part A (H89) Estimated Unobligated Balance Report and Estimated Carry Over Request by December 31 each year, if they intend to carryover RWHAP Part A formula funds, regardless of the amount of remaining funds. Each year, DMHAP distributes a letter with guidance and suggested format for submitting the Estimated UOB and Estimated Carryover Request.

Note: If a recipient does not submit an Estimated UOB and Estimated Carryover Request, and later identifies and reports unobligated RWHAP Part A formula funds in the final Federal Financial Report (FFR), the recipient will not be eligible to submit a carryover request for any RWHAP Part A formula UOB.

The estimated UOB is a required program submission that must be submitted electronically using the HRSA EHBs. Requests must contain the following information:

- Estimate of the UOB at the end of the grant year by subprogram (formula, supplemental, and MAI);
- Estimated amount of carryover formula and/or MAI funds;
- Source of the unexpended carry over funds by subprogram and program cost categories (administrative, clinical quality management, and HIV core medical and support services);
- Proposed use of funds;
- Detailed explanation for any unexpended prior year formula carryover and/or MAI carryover funds; and
- Concurrence from the RWHAP Part A PC/PB regarding the documentation and proposed use of carryover funds.

Final Unobligated Balance and Carryover Request

The exact amount of UOB must be reported on a final FFR due 90 days after the end of the grant year. In addition, the recipient must submit a final carryover request with their final FFR or within 30 days of submitting the final FFR, containing the actual amount of UOB. Final carryover requests must be submitted as a prior approval request in the HRSA EHBs.

DGMO must reconcile the final FFR with financial reports in the PMS prior to review of carryover requests. HRSA will return to the recipient for resubmission any carryover request that exceeds the amount available for carryover or does not include all required information. In reviewing requests for approval of carryover funds, HRSA will also assess the following:

- History of expenditures and carryover requests;
- Intended purpose and budget justification for the request (Note: Carryover funds cannot be used for administrative costs);
- Performance issues; and
- Timeliness of FFR submission, if relevant.

Requests for carryover will be considered on a case-by-case basis. Where appropriate, HRSA will exercise its authority to offset future grant awards. If a recipient's carryover request is approved by HRSA, the recipient will be issued the carryover funds in an NoA and will be able to expend the approved UOB in accordance with the purpose stated in the carryover request. If funds are not expended in the carryover year, they cannot be used in a subsequent year.

A complete description of carryover, UOB, and its penalties can be found in HAB [PCN #12-02](#).

If there are questions regarding carryover requests, recipients should consult with their designated HAB DMHAP PO and/or OFAM GMS.

V. Chapter 7. Technical Assistance, Links, and Resources

HHS Grants Policy Statement, January 2007:

<https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>.

National Monitoring Standards: <https://ryanwhite.hrsa.gov/grants/manage/recipient-resources>.

HRSA HAB PCNs and Policy Notices: <https://ryanwhite.hrsa.gov/grants/policy-notice>

HRSA HAB Program Letters: <https://ryanwhite.hrsa.gov/grants/program-letters>

2 CFR Part 200: <https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200>

HHS HRSA HAB Notices of Funding Opportunity: Search for NOFOs on HRSA HAB website at <https://www.hrsa.gov/grants/find-funding?status=All&bureau=644> or Grants.gov <https://www.grants.gov/>

RWHAP Recipient Resources: <https://ryanwhite.hrsa.gov/grants/manage/reporting-requirements>

Section VI: Reporting Requirements

VI. Chapter 1. Overview

All recipients receiving federal funds are required to report fiscal and program information to the agency designated to administer the particular grant program. For RWHAP Part A recipients, that agency is HRSA HAB. In addition, the RWHAP legislation requires some specific reports from recipients that HRSA HAB must collect and review. The process to review and approve recipient reporting is determined by the type of report. Programmatic reports (e.g., the Program Terms Report (PTR)) are reviewed and approved by the HAB DMHAP PO. Fiscal reports (e.g., the FFR) are reviewed and approved by a GMS in the DGMO, and data reports (e.g., Ryan White HIV/AIDS Program Services Report (RSR)) are reviewed by HRSA HAB's DPD and by HAB DMHAP PO.

In general, reports are required for one or more of the following reasons:

- To assure recipient compliance with requirements mandated by Congress on the use of RWHAP Part A funds. For example, RWHAP legislation requires RWHAP Part A and Part B recipients to use a proportionate amount of the grant funding to provide services to WICY with HIV. Recipients must submit WICY Expenditures Reports or waiver requests with the APR.
- To monitor the fiscal and programmatic integrity of the grant program, as required by legislation, regulatory, and policy requirements, as well as RWHAP Part A program expectations. For example, recipients are required to submit fiscal and programmatic information about subrecipients, including the RWHAP Part A Consolidated List of Contractors (CLC).
- To monitor and track program activities and trends, prepare HRSA HAB reports on program accomplishments, and respond to inquiries from Congress, the OMB, the media, and the public at large. HRSA HAB is responsible for the fiscal and program integrity of RWHAP Part A recipients. HRSA HAB staff must be able to monitor and report on recipients' fiscal status, services provided, clients served, program accomplishments, and TA needs. Reporting requirements also are used by HRSA HAB to assess client outcomes and understand service utilization. For example, the RSR is a reporting requirement that supports HRSA HAB to meet these needs.

HRSA HAB also provides the software package CAREWare at no monetary charge for use in collecting and reporting client-level data necessary for completion of the RSR. Use of CAREWare is not required; however, recipients and service providers can use CAREWare to generate their annual reports for submission to HRSA HAB. Recipients must demonstrate reasonableness of cost for data systems charged to the RWAHP Part A award.

VI. Chapter 2. Relevant Authorities

Legislative Requirements Regarding Use of Funds

To meet RWHAP legislative, regulatory, and programmatic requirements, recipients must submit reports regarding the use of funds in accordance with applicable provisions. Some examples of legislatively mandated reporting requirements include the RWHAP Part A Unobligated Balance Estimate and Estimated Carryover Request, the final FFR, and the WICY Expenditures Report.

Uniform Administrative Requirements and HHS Grants Policy Statement

The UAR provides the basis for systematic and periodic collection of information on all federal financial assistance programs. The HHS GPS makes the general terms and conditions of HHS discretionary grant and cooperative agreement awards available in a single document. These general terms and conditions are common across all HHS OPDIVs and apply as indicated in the HHS GPS, unless there are legislative, regulatory, or award-specific requirements to the contrary. All other reporting requirements for the RWHAP Part A are mandated by the UAR and/or grants policy. These include the final FFR and the MAI Annual Report.

General and award-specific requirements are outlined on NoAs as Grant Specific Term(s), Program Specific Term(s), Standard Term(s), Reporting Requirement(s), Condition(s), and/or Remark(s). All requirements (general and award-specific) are described in the NoA. Grant-specific terms set criteria or limits on how grant funds may be used.

Failure to comply with the NoA's general and award-specific requirements may result in enforcement actions, including a drawdown restriction being placed on the recipient's PMS account, the disallowance of funds, and/or other conditions. The Grants Management Officer (GMO), in collaboration with the HAB DMHAP PO, may include award-specific conditions to require correction of identified financial or administrative deficiencies, including submission of corrections or missing reports. When specific award conditions are imposed, the GMO and/or the HAB DMHAP PO will notify the recipient of the nature of the condition(s), the reason why the condition(s) is being imposed, the type of corrective action(s) needed, the time allowed for completing the corrective action(s), and the method for requesting reconsideration of the condition(s). For additional information, see 2CFR § 200.208.

VI. Chapter 3. RWHAP Part A Submission Requirements

HRSA HAB posts competitive announcements for RWHAP Part A funding through a NOFO on Grants.gov. The NOFO includes all substantive grant provisions, such as application requirements and evaluation criteria. HRSA HAB requires a RWHAP Part A Program Competitive Application for Non-Construction Programs every three years. In the three-year period of performance, eligible applicants are required to submit a competitive application in the first year and NCC Progress Reports for Year 2 and Year 3. While the competitive application is

submitted through Grants.gov, the NCC Progress Report must be submitted through the HRSA EHBs for continued funding during Year 2 and Year 3 of the three-year period of performance.

The NCC Progress Report includes several components: the SF-PPR, the SF-PPR2, as well as program-specific requirements such as, but not limited to, an SF-424A, budget narrative, Core Medical Services Waiver Attestation Form (if applicable), and MOE documentation submitted in each year of the period of performance. Indirect cost rate agreements are submitted in the competitive year (if applicable) and submitted in Year 2 or Year 3 of the period of performance only if the submitted documentation expired or indirect costs are being charged to the grant for the first time. Furthermore, assurances are required with the NCC Progress Reports. The elements reported in the programmatic sections of the NCC Progress Report are used for the RWHAP Part A formula funding calculations.

NCC Progress Report user guides and instructions are available in the HRSA EHBs and on the HRSA website. Failure to submit the NCC Progress Report by the established deadline or submission of an incomplete or nonresponsive NCC Progress Report may result in a delay in NoA issuance.

Reporting Requirements

Recipients are required, as a Condition of Award, to provide certain program and fiscal reports each year. The table below provides a description of each RWHAP Part A reporting requirement, its purpose, and the general due date. During the grant year, HAB DMHAP provides recipient training webinars and distributes detailed instructions on how to prepare and submit reporting requirements. Guidelines and submission instructions are also provided via the HRSA EHBs and are available through the HAB DMHAP PO. All reports are submitted through the HRSA EHBs or other web-based systems. Please refer to the NoA, NOFO, and the HRSA EHBs for budget period-specific requirements and exact due dates.

For the precise deadline date, refer to the Reporting Requirements section on the NoA and/or the HRSA EHBs reporting instructions issued each year by HRSA HAB. To meet the deadline, the information must be in the HRSA EHBs by the due date. Recipients are expected to comply with all reporting deadlines. Once the deadline date passes, the HRSA EHBs will close submission access, and the recipient must submit a due date extension request to the HRSA HAB PO or OFAM GMS to open the file. If late reporting persists, special terms and/or conditions may be imposed on the recipient, or funding implications implemented, until the problem of late reporting has been corrected.

See the table below for a listing of the RWHAP Part A annual reporting requirements, descriptions for each, and respective due dates.

Reporting Requirement	Deadline	Description/Purpose
<p>Program Terms Report (PTR)</p>	<p>60 days following final award issue date or by the date indicated in EHB, whichever is earlier</p>	<p>An aggregate report submission consisting of two components, the Consolidated List of Contractors (CLC) and the Allocations Table. PTR components are dependent on the entry of contract information into a single system called the Grantee Contract Management System (GCMS). The GCMS reduces burden by allowing recipients to enter both HIV service and non-HIV service contract information into one system, which then generates both the CLC and Allocations Table. Both the GCMS and PTR web application can be accessed via the HRSA EHBs.</p> <p>a. CLC identifies the name, contract amount, and service/activity to be provided for all HIV core medical and support services subawards, contracts, or other legal agreements using RWHAP Part A grant funding. This summary information helps HRSA monitor and track the use of grant funds for compliance with program and grants policies and requirements.</p> <p>Information entered into the GCMS generates the CLC. Therefore, all contract information must be entered into the GCMS for a current grant/budget year, including all executed contracts, contracts in the process of execution, and any planned contracts. GCMS enhancements allow entry of unexecuted contract information, as well as placeholder information on intended or planned contracts (e.g., a subrecipient provider or contractor not yet identified). The entry of information on all contract types ensures the generation of a complete CLC submission.</p> <p>b. Allocations Report is submitted on an OMB-approved form and indicates the categories and PC/PB priority areas (core medical and support service categories) for the current budget period and the funding dollar amount for each service category. Planned allocations of RWHAP Part A formula, supplemental, and MAI funding to service categories identified by the PC/PB are included. Formula and supplemental funds are reported in the aggregate in the table, while MAI funds are listed separately. The table also includes the planned allocation of funds for administration and CQM. The service category contract amounts entered in the GCMS automatically populate the Allocations Table.</p>
<p>Unobligated Balance (UOB) Estimate and Carryover Estimate</p>	<p>December 31, annually</p>	<p>A report on the estimated amount of RWHAP Part A formula grant funds and MAI funds the EMA/TGA anticipates will be unobligated at the end of the grant budget year and an estimated carryover request of those funds. This request must be submitted each year, consistent with reporting guidelines, instructions, and/or reporting templates provided in the HRSA EHBs. Though not a reporting requirement, this report is a prior approval and must be submitted in the EHB as such. There are</p>

Reporting Requirement	Deadline	Description/Purpose
		<p>statutory penalties specific to UOB that exceeds five percent of the formula award. For detailed information on the UOB Estimate and Carryover Waiver, see hab-part-uob-policy.pdf (hrsa.gov) – Ryan White Part A and Part B Unobligated Balances and Carryover Provisions.</p>
<p>Ryan White HIV/AIDS Program Services Report (RSR)</p>	<p>Last Monday in March, annually</p>	<p>Collects information on recipients, subrecipient providers, and clients served by the RWHAP (excluding ADAP) during a calendar year. Since 2010, client-level RSR data have been used to understand demographic characteristics, service utilization, and clinical outcomes of clients receiving RWHAP services.</p> <p>The RSR includes three main components: the Recipient Report, the Provider Report, and the Client-Level Data Report. The Recipient Report collects general information on the recipient and identifies each funded subrecipient. The Provider Report collects basic information about both the provider and the services the provider delivered under each of its RWHAP contracts. The Client-Level Data Report contains information on demographic characteristics, HIV clinical information, and service utilization for RWHAP clients who received core medical or support services during the reporting period. All client-level data are de-identified, and all measures have been taken on the part of HRSA HAB to protect the data.</p> <p>All RWHAP recipients are responsible for coordinating with and ensuring reporting of each funded subrecipient. All RWHAP recipients are responsible for training service providers and any other reporting entities on collecting and reporting data for the RSR. Recipients also are responsible for the following:</p> <ul style="list-style-type: none"> • Reviewing service provider reports to ensure accuracy prior to submitting to HRSA HAB; • Submitting completed data reports to HRSA HAB by the deadline provided; and • Cooperating in verification of data following submission. <p>Information and instructions on completing these reports can be found in the RSR Instruction Manual. HRSA HAB supports TA providers and provides tools that can assist both recipients and subrecipients in addressing issues related to the RSR, CAREWare, and HRSA EHBs. For more information on RWHAP data support, visit: Report Data and Receive Technical Assistance Ryan White HIV/AIDS Program (hrsa.gov).</p>

Reporting Requirement	Deadline	Description/Purpose
Annual Progress Report	90 days after budget period end date	<p>A report consisting of multiple components. Each component reports on various aspects of the EMA/TGA RWHAP Part A recipient’s progress in meeting program goals as well as other program requirements. Brief descriptions for each of the components are as follows:</p> <p>a. Program Narrative:</p> <ul style="list-style-type: none"> • Early Identification of Individuals with HIV/AIDS (EIIHA) Update: Description of actions taken with each EIIHA activity and how actions met subpopulation(s) of focus needs, as applicable. Quantifiable results (measurable outcomes) are provided for each EIIHA activity. • Subpopulations of Focus: description of identified subpopulations of focus and associated viral suppression rates, and a description of MAI services provided to identified subpopulations, as applicable. • Unmet Need: description of progress and measurable outcomes of interventions and how they supported ending the epidemic initiatives. Description of interventions not implemented including reasoning. • Integrated HIV Prevention and Care Plan: description of progress on goals, objectives, and quantifiable results over the period of performance. Highlighting key activities implemented and measurable outcomes in the current budget period. Description of collaboration efforts and measurable outcomes, for Planning Councils/Planning Bodies, Stakeholders, Community engagement, Workgroups, Evaluation or data gathered from collaboration activities, and/or New partnerships or priority populations. <p>b. Final Service Category Table and HIV Care Continuum Service Tables and Narrative includes targets as well as actuals for spending, service utilization, and outcomes data on the Service Category Plan Table and HIV care continuum table. A narrative is required to explain any variances in spending/service utilization, as well as a discussion of health outcomes using baseline, target, and actual figures.</p> <p>c. WICY Expenditures Report - legislation requires RWHAP Part A recipients to use a proportionate amount of their grant dollars to provide services to WICY with HIV. Each year, CDC supplies the updated WICY data to HRSA HAB to help recipients prepare the EMA/TGA’s report of WICY expenditures. HRSA HAB suggested workbooks assist RWHAP</p>

Reporting Requirement	Deadline	Description/Purpose
		<p>Part A recipients with the preparation of the required annual WICY Expenditure Report.</p> <p>d. Planning Council/Planning Body Report is a narrative report on PC/PB accomplishments and challenges related to implementation of legislative requirements (e.g., reflectiveness and representation, needs assessment, priority setting, and resource allocation, etc.).</p>
<p>RWHAP Part A and MAI Final Expenditures Table</p>	<p>90 days after budget period end date</p>	<p>Report actual RWHAP Part A and MAI grant fund expenditures by service category to update information submitted on the Allocations Report. Recipients demonstrate compliance with the 75 percent core medical services requirement through this report. The amount reported on the expenditures report must match the expenditures reported on the final FFR, and expenditures by category must match those reported in the RWHAP Part A Service Category Table submitted with the APR. Recipients will be required to certify HIV services aggregate administrative expenditures. The report is submitted on OMB-approved reporting guidelines, instructions, and/or reporting templates provided in the HRSA EHBs and as found in the RWHAP Part A PTR and Expenditures Report Manual.</p>

Reporting Requirement	Deadline	Description/Purpose
<p>Final Federal Financial Report (FFR)</p>	<p>The FFR for RWHAP Part A is due May 29.</p> <p>The FFR due dates have been aligned with the PMS quarterly report due dates and will be due 90 days after the budget period end date.</p>	<p>An annual financial report, SF-425, which indicates how much money has been drawn down through the PMS, what funds were expended, and the remaining balance left at the end of the reporting period. The report must also include program income collected during the budget period. The report, submitted through the PMS, requires the recipient to report the cumulative expenses within the budget period. The cumulative expenses must not include unliquidated obligations and must agree with the PMS report of disbursements and advances for the budget period being reported. Technical questions regarding the FFR, including system access should be directed to the PMS Help Desk by submitting a ticket through the self-service web portal (PMS Self-Service Web Portal), or calling 877-614-5533.</p> <p>If the recipient has an UOB, it must do one of the following:</p> <ol style="list-style-type: none"> a. Submit a completed carryover request through the HRSA EHBs Prior Approval Module, even if the request is attached with the submission of the FFR. b. Indicate on the FFR their intent to submit a carryover request separately and submit the request via the Prior Approval Module, within 30 days of the FFR submission. c. Indicate on the FFR their intention to not submit any carryover request. <p>If a recipient does not submit a waiver/estimated UOB (as outlined in the UOB Estimate and Carryover Estimate reporting requirement), and later identifies and reports unobligated RWHAP Part A formula funds in the final FFR, the recipient will not be eligible to submit carryover request for any RWHAP Part A formula UOB.</p> <p>Reporting Program Income</p> <p>Total program income earned by the recipient is reported on line l of the SF-425. Recipients must not report program income earned by subrecipients in the FFR.</p> <p>Because program income is only additive and not deductive for the RWHAP, nothing should be entered on line m. The amount of program income that was added to funds committed to the total project costs and expended to further eligible program activities is entered on line n. The amount of program income that was earned but not expended is automatically calculated and appears on line o.</p> <p>For more information on program income, see Section V, Grants Administration, Chapter V.</p>

Reporting Requirement	Deadline	Description/Purpose
UOB/Carryover Request	No later than 30 days after the final FFR due date	A request by the recipient to carryover actual UOB into the subsequent budget period, including the planned use of those funds. The carryover request cannot exceed the UOB reported in the approved final FFR. Recipients must submit their final FFR prior to submitting a carryover request. If a recipient chooses to submit a carryover request, it can be submitted at the same time as the final FFR or submitted within 30 days of the final FFR due date via the Prior Approval Module in the HRSA EHBs. HRSA HAB will not review a carryover request until after the final FFR is accepted. See Section V, Grants Administration, Chapter 6, Unobligated Balance and Carryover Request, for additional information on carryover request requirements.

For questions about reporting requirements, staff should contact their assigned RWHAP Part A PO.

VI. Chapter 4. Electronic Handbooks

In an effort to increase the efficiency and effectiveness of its management of recipient records, HRSA has developed an electronic record keeping system, the HRSA EHBs, which provide a one-stop grants management online tool for POs and recipients. The HRSA EHBs provide accessibility to all grant-related documents (e.g., grant applications, NoAs, and other types of post-award submissions) for POs and recipients. Additionally, the HRSA EHBs provide information on submission deadlines and access to other RWHAP reports, such as the RSR.

Any information and data required from the recipient, such as applications, draw down restriction requests, reports, and waivers, must be submitted using the format provided by HRSA, as outlined in the HRSA EHBs. The HRSA EHBs reporting formats help to assure that correct information is reported across all RWHAP recipients. This, in turn, allows HRSA to track and report national program trends and health outcomes, identify TA, and prepare aggregate summary reports for Congress, recipients, and the public at large.

To access the recipient’s grant portfolio in the HRSA EHBs, a recipient must register in the HRSA EHBs and authorize recipient staff to have certain roles on behalf of the recipient. Information on HRSA EHBs registration, as well as general information on use of the HRSA EHBs portal, can be accessed at the following link:
<https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/UserRegistration/RegistrationHome.as>.

For access to the HRSA EHBs system go to: <https://grants.hrsa.gov/webexternal/login.asp>.

Additional help is available from the HRSA Call Center at:

- Phone: 877-Go4-HRSA/877-464-4772
- Times: 9:00 a.m. to 5:30 p.m. (Eastern Time)
- Days: Monday through Friday
- Email: CallCenter@hrsa.gov

VI. Chapter 5. Technical Assistance, Links, and Resources

The Ryan White HIV/AIDS Program Services Report (RSR):

<https://ryanwhite.hrsa.gov/grants/manage/reporting-requirements/rsr>

HHS Grants Policy Statement: <https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>

SF-424 Application Guide:

<https://www.hrsa.gov/sites/default/files/hrsa/grants/apply/applicationguide/sf-424-app-guide.pdf>

2 CFR Part 200: <https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200>

Section VII: Recipient and Subrecipient Monitoring

VII. Chapter 1. Overview

Monitoring, whether HRSA is monitoring recipients, recipients are monitoring subrecipients, or the recipient and subrecipient are monitoring contractors, is a critical component of the RWHAP. This section provides a high-level overview of the oversight and monitoring responsibilities of recipients and subrecipients, as well as information regarding useful tools that will assist with providing oversight of both subrecipients and contractors.

VII. Chapter 2. Relevant Authorities

Definitions and Roles

The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (UAR) establishes the following relevant definitions in 2 CFR § 200.1 pertaining to awarding of federal funding:

- **Federal awarding agency** – defined as “the Federal agency that provides a Federal award directly to a non-Federal entity.”
- **Recipients** – defined as “an entity, usually but not limited to non-Federal entities that receives a Federal award directly from a Federal awarding agency to carry out an activity under a Federal program. The term recipient does not include subrecipients.”
- **Pass-through entities** – defined as “a non-Federal entity that provides a subaward to a subrecipient to carry out part of a Federal program.” A pass-through entity may be a recipient or subrecipient.
- **Subrecipients** – defined as “a non-Federal entity that receives a subaward from a pass-through entity to carry out part of a Federal program; but does not include an individual that is a beneficiary of such program. A subrecipient may also be a recipient of other Federal awards directly from a Federal awarding agency.”
- **Contractors** – defined as “an entity that receives a contract,” which is defined as “a legal instrument by which a non-Federal entity purchases property or services needed to carry out the project or program under a Federal award.”

Please note that the RWHAP legislation uses the term “subcontractor” in reference to entities that receive funding directly from the recipient or from a lead agency acting on behalf of the recipient. In this context, subcontractor is synonymous with subrecipient.

The UAR also clarifies the role of the recipient and subrecipient with regard to the following:

- Procurement standards (2 CFR § 200.317 – 200.327, particularly 2 CFR § 200.317 – 200.320);
- Performance and financial monitoring and reporting (2 CFR § 200.328-75.330);

- Access to records related to a federal award (2 CFR § 200.337);
- Distinguishing subrecipients from contractors (2 CFR § 200.331); and
- Subrecipient monitoring and management/requirements for pass-through entities (2 CFR § 200.332).

Oversight and Monitoring

All RWHAP Part A recipients are responsible for adequate oversight and monitoring of all activities supported by the federal award, including subawards and contracts. Per 2 CFR § 200.329(a):

The recipient and subrecipient are responsible for the oversight of the Federal award. The recipient and subrecipient must monitor their activities under Federal awards to ensure they are compliant with all requirements and meeting performance expectations. Monitoring by the recipient and subrecipient must cover each program, function, or activity.

All RWHAP Part A recipients, subrecipients, and contractors must ensure proper procedures and oversight in the procurement of subawards and contracts and ensure that all requirements under the grant are satisfied across subrecipients and contractors.

Per general procurement standards in 2 CFR § 200.318(a):

When procuring property and services under a Federal award, the recipient or subrecipient must maintain and use documented procedures for procurement transactions under a Federal award or subaward, including for acquisition of property or services. These documented procurement procedures must be consistent with State, local, and tribal laws and regulations and the standards identified in [§§ 200.317](#) through [200.327](#).

Subrecipients must use their own procurement procedures that reflect applicable state/territory and local laws and regulations. Contracts must contain the clauses necessary to ensure that all requirements under the grant will be satisfied, since neither the CFR and its various Parts nor other documents are directly binding on a contractor. Per 2 CFR Appendix II to Part 200, contracts should specify the:

- Nature and number of services to be provided;
- Eligibility requirements for enrollment of people with HIV in services;
- Line-item budget and/or a payment rate per unit per service;
- Nature and frequency of required reports;
- Data collection criteria and expected reporting;
- Processes for reimbursement payments including invoicing and time frames;
- Program and fiscal monitoring processes and time frame; and
- Quality management expectations.

Access to all applicable records and staff is required to ensure appropriate oversight and monitoring. Per 2 CFR § 200.337(a):

The Federal agency or pass-through entity, Inspectors General, the Comptroller General of the United States, or any of their authorized representatives must have the right of access to any records of the recipient or subrecipient pertinent to the Federal award to perform audits, execute site visits, or for any other official use. This right also includes timely and reasonable access to the recipient's or subrecipient's personnel for the purpose of interview and discussion related to such documents or the Federal award in general.

Per 2 CFR § 200.332, all RWHAP Part A recipients must ensure that any subaward (including those made by a lead agency) is clearly identified as a subaward and includes information regarding all federal requirements pertaining to the award. The subaward must also include any additional requirements imposed by the pass-through entity to meet its responsibilities to the HHS awarding agency (i.e., HRSA HAB).

All RWHAP Part A recipients also are responsible for ensuring the following and related activities:

- The evaluation of subrecipient risk for non-compliance;
- The monitoring of subrecipient activities to ensure compliance and that performance goals are met;
- Verification of subrecipient auditing; and
- Enforcement action is taken as appropriate to address noncompliance.

Distinguishing between Subrecipients and Contractors

All RWHAP Part A recipients, subrecipients, and contractors should review 2 CFR § 200.331 in its entirety and use judgment in classifying legal agreements as subawards or contracts based on the substance of the agreement or relationship. Per 2 CFR § 200.331: “a subaward is for the purpose of carrying out a portion of a Federal award and creates a Federal assistance relationship with the subrecipient,” and, “a contract is for the purpose of obtaining goods and services for the recipient's or subrecipient's own use and creates a procurement relationship with the contractor.”

Furthermore,

*The pass-through entity must use judgment in classifying each agreement as a subaward or a procurement contract. In making this determination, **the substance of the relationship is more important than the form of the agreement.***

Therefore, pass-through entities must use the **substance of a legal agreement or relationship** to determine whether the non-federal entity with which it has a legal agreement is a subrecipient or a contractor, regardless of the type of legal agreement or the term used when referencing the legal agreement.

Other Relevant Definitions and Information

Subrecipient – Entity receiving an RWHAP Part A subaward from the RWHAP Part A recipient or direct service provider. Subrecipients may also include entities receiving an RWHAP Part A contract if the substance of the relationship aligns with the definition of a subaward (i.e., for the purpose of carrying out a portion of a federal award). The RWHAP Part A recipient is accountable to HRSA HAB for adequate oversight and monitoring of all activities supported by the federal award, including subawards and contracts.

Lead Agency – An entity with which the recipient establishes a legal agreement to manage grant administrative responsibilities, including procurement, payment, and monitoring of subrecipients to ensure delivery of comprehensive services to people with HIV in the EMA/TGA. The recipient may fund the lead agency to conduct these activities for a specific region(s) or for the entire jurisdiction. Lead agencies are often pass-through entities that issue subawards or contracts to direct service providers. Lead agencies may also receive a subaward from the recipient to deliver direct services to people with HIV.

The RWHAP Part A recipient must ensure it monitors lead agencies as it would other subrecipients.

Direct Service Provider – An entity with which the recipient establishes a legal agreement to provide RWHAP HIV core medical and support services to people with HIV. Direct service providers may include ambulatory medical clinics, public health departments, institutions of higher education, state/territory and local governments, non-profit organizations, faith-based and community-based organizations, and tribes and tribal organizations. Direct service providers for RWHAP Part A may also be the RWHAP recipient or subrecipient from other RWHAP Parts or an entity that serves as a lead agency. Direct service providers may include for-profit entities when they are the only available providers of quality HIV care in a jurisdiction and comply with all requirements of [PCN #11-02](#), Clarification of Legislative Language Regarding Contracting with For Profit Entities.

The RWHAP Part A recipient must ensure it monitors all direct service providers as subrecipients. If an entity is both a direct service provider and a lead agency, the recipient must ensure that each legal agreement is appropriately monitored.

Fiduciary Agent – A fiduciary agent is an entity with which the recipient establishes a legal agreement to do one or more of the following: manage grant funds; manage procurement processes; manage payment of invoices; ensure funds are used for allowable purposes and in accordance with applicable legislative, regulatory, and programmatic requirements; and/or execute award requirements related to non-compliance.

Fiduciary agents typically conduct fiscal activities on behalf of the recipient in an administrative capacity and do not provide direct services to people with HIV or have a direct relationship with direct service providers. In addition, fiduciary agents are typically not involved in programmatic decision-making (e.g., planning, priority-setting, and eligibility determination).

Depending on the substance of the relationship, a fiduciary agent may be a subrecipient or a contractor. Recipients should use the content of the legal agreement, including the statement of work, to determine whether subrecipient monitoring is required.

VII. Chapter 3. National Monitoring Standards

The NMS are a TA resource to support recipients and subrecipients in meeting federal requirements for program and fiscal management, monitoring, reporting, and oversight of the RWHAP Parts A and B and to improve program efficiency and responsiveness.

The NMS consolidate requirements set forth in relevant authorities and outline suggested standards for how recipients and subrecipients can meet those requirements. As such, the NMS do not establish or impose legislative, regulatory, or programmatic requirements; rather, they provide guidance on how recipients and lead agencies can meet requirements and monitor those who have been issued subawards.

The NMS include Program, Fiscal, and Universal components. There are separate NMS for RWHAP Parts A and B. The Universal component addresses general requirements for both the RWHAP Parts A and B. The NMS are organized by legislative, regulatory, and programmatic requirements. For each requirement, suggested standards for meeting the requirement are provided, including performance measures/methods, and recipient and subrecipient responsibilities. Performance measures/methods provide guidance on how to meet each requirement. Recipient and subrecipient responsibilities outline approaches for meeting or verifying compliance with the requirement. HRSA HAB's provision of the NMS does not supplant the recipient or subrecipient responsibility for reading and complying with all current and relevant authorities.

The NMS can support recipients and subrecipients in the following ways:

- Preparing for recipient or subrecipient site visits conducted by HRSA HAB, the recipient, or an entity working on behalf of the recipient;
- Developing subrecipient monitoring protocols and tools; and
- Ensuring recipients and subrecipients meet legislative, regulatory, and programmatic requirements.

During annual subrecipient monitoring site visits conducted by the recipient or an entity working on behalf of the recipient, the NMS can be used to assess subrecipient compliance with legislative, regulatory, and programmatic requirements. Therefore, recipient and subrecipient fiscal and program staff should be familiar with all components of the NMS. If there are questions regarding the content of the NMS, please contact the HRSA HAB PO.

The NMS are periodically updated and can be accessed at the following link:

<https://ryanwhite.hrsa.gov/grants/manage/recipient-resources>.

VII. Chapter 4. HRSA Monitoring of RWHAP Part A Recipients

HRSA HAB provides federal monitoring and oversight of the RWHAP Part A. Federal monitoring and oversight include assessing recipient operations and performance, promoting economy and efficiency in recipient operations, and ensuring recipient compliance with RWHAP Part A legislative, regulatory, and programmatic requirements.

The scope of federal monitoring and oversight includes all administrative, fiscal, and program activities under RWHAP Part A and applies to any project, program, function, or activity supported by the RWHAP Part A award directly or through subaward, contract, or other legal agreement. Therefore, federal monitoring applies to all directly funded RWHAP Part A non-federal entities in their roles as recipients of federal awards, in their role as a pass-through entity, and/or in their implementation of subawards, contracts, or other legal agreements. HAB DMHAP monitoring does not extend to subrecipients.

The monitoring of recipients includes the provision of technical assistance assessments, which may be requested by POs or by recipients. TA can be provided using a range of modalities, including on-site visit, tool and resource development, telephone consultation, peer consultation, and webinars.

Site Visits to RWHAP Part A Recipients

Site visits are a key component of HAB DMHAP oversight of RWHAP Part A recipients to verify and ensure compliance with RWHAP Part A legislative, regulatory, and programmatic requirements; provide high-quality HIV clinical care in accordance with HHS guidelines; and ensure administrative and fiscal integrity.

HAB DMHAP conducts three types of site visits: comprehensive, diagnostic, and technical assistance. HRSA HAB has implemented a risk-based strategy for scheduling recipient site visits and for choosing the appropriate type of site visit.

Comprehensive Site Visit

The purpose of a CSV is to:

- 1) Assess legislative, regulatory, and programmatic compliance of the RWHAP Part A;
- 2) Review and ensure the recipient makes progress in planning and implementing proposed programs/projects;
- 3) Provide recommendations for areas of improvement; and
- 4) Identify strengths.

RWHAP Part A CSVs are scheduled every four years. During the site visit, a team of internal HRSA HAB staff and/or external consultants conducts an assessment of the entire RWHAP Part A, including program administration, CQM, and fiscal systems management. This assessment may result in the identification of legislative and/or programmatic findings, performance improvement options, and programmatic strengths. The site visit team may also

provide on-site TA and/or identify TA needs to assist recipients in meeting legislative and regulatory requirements and program expectations. Following the visit, recipients will receive a site visit report documenting all findings identified and discussed during the CSV Exit Conference.

When a legislative, regulatory, or programmatic finding (i.e., area of non-compliance) is identified during a site visit, the recipient must create a corrective action plan (CAP), in conjunction with the HAB DMHAP PO, to address deficiencies and bring the program into compliance. The designated HAB DMHAP PO will work with recipients to resolve deficiencies. A recipient may request TA to support implementation of the CAP.

If a recipient does not correct legislative and programmatic/fiscal non-compliance findings generated by a monitoring site visit (in a timely manner) and does not request TA to correct such deficiencies, more intensive monitoring and restrictions will result. This can include a special “condition of award” on the RWHAP Part A grant and/or restrictions on the drawdown of funds. The conditions include a clear statement of the obligations that are not being met and a timetable for establishing and implementing a CAP.

Diagnostic Site Visits

The purpose of a diagnostic site visit is to address a significant concern or issue identified through HAB DMHAP PO monitoring, recipient self-assessment, and/or audit findings. Concerns or issues that may lead to a diagnostic site visit include:

- A previously identified programmatic, fiscal, or administrative deficiency that the recipient has failed to correct within a specified time frame;
- An emerging issue or situation that may lead the recipient to be unable to meet the terms of the award;
- Persistent recipient non-compliance with conditions of award, program terms, or reporting requirements; or
- The result of an audit finding.

During the site visit, a team of internal HRSA HAB staff and/or external consultants examines and analyzes factors contributing to identified concerns or issues. The team may also review previous comprehensive site visit reports and corresponding CAPs submitted by the recipient. Following the visit, recipients will receive a report outlining the assessment provided, any findings, and recommendations for improvement. The designated HAB DMHAP PO will work with recipients to resolve findings.

Diagnostic site visits are scheduled by HAB DMHAP as needed.

Technical Assistance Site Visits

The purpose of a TA site visit is to provide tailored training, capacity-building assistance, instruction, or staff orientation around an identified area of need for a specific RWHAP Part A recipient. The need for TA may be identified through HAB DMHAP PO monitoring, during

application review, during a site visit, or by the recipient. TA may address any legislative or programmatic area (e.g., CQM, fiscal, or administrative) and may focus on a range of topics (e.g., succession planning, quality management, management information systems, strategic planning, governance, etc.).

TA site visits are most often conducted by HRSA HAB external consultants. During the TA site visit, external consultants work with the recipient's administrative staff, program staff, or program directors to address the identified need. The site visit may result in the identification of areas for performance improvement, best practices, or innovative practices. Following the visit, recipients will receive a TA site visit report outlining the TA provided and any additional recommendations for improvement.

TA site visits are scheduled as needed and as prioritized by HAB DMHAP.

VII. Chapter 5 Monitoring of RWHAP Part A Subrecipients

The RWHAP Part A recipient is held accountable by HRSA HAB for all subawards, contracts, or other legal agreements awarded through the RWHAP Part A grant. For example, in the case of an OIG finding that results in repayment of federal dollars, the recipient, not the subrecipient or contractor, is responsible for repaying the debt out of non-federal dollars.

Recipients should use their monitoring process and legal agreement language to establish expectations and to reinforce and underscore mutual obligations between the recipient and the subrecipient. The recipient should have an established monitoring process that designates a person or team to review fiscal and program reports, conduct site visits, interact on an ongoing basis with contracted providers, and implement a CAP or other corrective action, if necessary. If a recipient chooses to distribute monitoring functions across its organization, the recipient should ensure appropriate communication among those responsible for programmatic and fiscal monitoring. Recipients may choose to assign monitoring functions to an entity working on behalf of the recipient.

The monitoring process for subrecipients should be standardized, transparent, and encompass the full range of monitoring and oversight activities required, including drafting and ensuring compliance with scopes of work, conducting desk compliance audits, analyzing performance reports, training recipient and subrecipient staff, and other required program and fiscal monitoring activities. In addition, it should describe and outline the process to be followed prior to, during, and after a monitoring site visit (see next section for more information).

Subrecipient monitoring requirements are outlined in 2 CFR § 200.332.

Annual Site Visits to RWHAP Part A Subrecipients

Recipients must ensure that all RWHAP Part A subrecipients receive an annual monitoring site visit, unless the recipient has an approved annual subrecipient site visit exemption from HAB DMHAP. In order to perform site visits of subrecipients when circumstances do not permit on-

site monitoring, HRSA HAB recommends performing remote/virtual site visits or other innovative strategies.

Recipients and other pass-through entities should establish a structured process or protocol and develop corresponding fiscal and program tools for annual site visits to each subrecipient to ensure review of the subrecipient's obligations in sufficient detail. A sound practice is to model the fiscal and program tools after the NMS. Site visits might include staff interviews, observation of services, review of client records or charts, a facility tour, and a review of various documentation to validate subrecipient operations are compliant with requirements. Desk audits are not a substitute for annual subrecipient site visits.

Review of client records or charts is one method by which recipients can assess compliance with service category definitions and established service standards and to validate services are provided within eligibility time periods. This review does not need to include all records or charts; a sufficient review can be accomplished by using an established random sampling methodology. Established protocols and tools should define and describe the sampling methodology based on the number of clients served, number and complexity of data to be reviewed in each client record or chart, and the methodology used for data review, extraction, and/or documentation.

Following a site visit, each subrecipient must receive a site visit report, including any legislative, regulatory, and/or programmatic non-compliance findings. Subrecipients should receive a site visit report within 45 business days after the site visit. The recipient or the entity working on behalf of the recipient ensures a CAP is developed to resolve all findings. The recipient must monitor the CAP to ensure its satisfactory completion.

Annual Subrecipient Site Visit Exemption

Recipients may submit a request for an exemption to conducting annual subrecipient site visits (see the 2023 [RWHAP Parts A and B Annual Site Visit Exemption](#) program letter). RWHAP Part A recipients must submit annual subrecipient site visit exemption requests by May 31st. To receive an exemption, the recipient must demonstrate that sufficient monitoring of subrecipients will continue to occur to ensure compliance with all RWHAP Part A legislative, regulatory, and programmatic requirements.

To submit a request for an exemption from the annual site visit requirement, recipients must notify their HAB DMHAP PO of their intention to request an exemption. The PO will initiate a Request for Information (RFI) in the HRSA EHBs. The recipient must respond to the HRSA EHBs task by the established due date with an exemption request that addresses the following:

- How many subrecipients does the program fund and monitor?
- What are the barriers and challenges to conducting annual site visits to all subrecipients?
- If the program is unable to conduct annual site visits, what is the frequency and/or schedule of visits that the program can conduct?
- How many years are needed to conduct a full cycle of visits to all subrecipients?
- Does the EMA or TGA have a site visit protocol? If so, include with request.

- What is the program’s monitoring plan during the years that subrecipients are not receiving a site visit?
- What is the program’s process for issuing and monitoring CAPs?

Recipients can request an exemption for one year or for multiple years. If submitting a multi-year exemption, recipients must submit a site visit timeline and comprehensive monitoring plan that is appropriate for the scope and complexity of the jurisdiction’s system of HIV care and treatment.

If the request is approved, the recipient will be notified. Recipients with approved waivers must provide updates on site visit monitoring activities to the designated HAB DMHAP PO. Recipients must obtain prior approval on any changes to their approved plan. When an approved exemption expires or is terminated due to non-compliance, recipients must submit a new exemption request for any subsequent year(s).

VII. Chapter 6. Technical Assistance, Links, and Resources

This section provides resources for recipient and subrecipient monitoring to ensure compliance with legislative, regulatory, and programmatic requirements.

HHS Grants Policy Statement: <https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>

National Monitoring Standards: <https://ryanwhite.hrsa.gov/grants/manage/recipient-resources>

HRSA HAB Policies: <https://ryanwhite.hrsa.gov/grants/policy-notice>

HRSA HAB Program Letters: <https://ryanwhite.hrsa.gov/grants/program-letters>

2 CFR Part 200: <https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200?toc=1>

HRSA Training; How to Manage Your Grant: <https://www.hrsa.gov/grants/manage-your-grant/training/how-to-manage-grant-guide>

Attachment 1:

RWHAP Part A Components, Requirements, and Caps

Components of the Part A Award

Formula Award	Funds are awarded based on the percent of total living case counts across all jurisdictions multiplied by the amount available for distribution. Must spend at least 95 percent of formula award or subjected to penalties.
Supplemental Award	Funds are awarded based on scores from objective review.
Minority AIDS Initiative Funds	Funds support services for minority populations and are based on the percent of total living minority case counts across all jurisdictions multiplied by the amount available for distribution.

Grant Requirements and Caps

Administrative Costs	Limited to 10 percent of the award. Includes PC costs as well as indirect costs. Subrecipient administrative costs are capped at 10 percent in the aggregate.
Clinical Quality Management Costs	CQM program not to exceed 5 percent of the grant award or \$3,000,000, whichever is less.
Salary Rate Limitation	Grant funds may not be used to pay salary rates in excess of the salary of Executive Level II.

Core and Support Services

Core Medical Services	Recipients must expend 75 percent of grant funds, minus the amount reserved for administration and CQM activities, on core medical services unless there is an approved waiver.
Support Services	RWHAP legislation does not stipulate how much recipients must expend on support services.

Appendix I: List of Common Acronyms

ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
APR	Annual Progress Report
CAP	Corrective Action Plan
CARE Act	Comprehensive AIDS Resources Emergency Act
CBDPP	Community Based Dental Partnership Program
CDC	Centers for Disease Control and Prevention
CEO	Chief Elected Official
CHIP	Children's Health Insurance Program
CLC	Consolidated List of Contractors
CQII	Center for Quality Improvement and Innovation
CQM	Clinical Quality Management
CSV	Comprehensive Site Visit
DCHAP	Division of Community HIV/AIDS Programs
DGMO	Division of Grants Management Operations
DIR	HRSA's Division of Independent Review
DMHAP	HAB's Division of Metropolitan HIV/AIDS Programs
DPD	HAB's Division of Policy and Data
DRP	HIV/AIDS Dental Reimbursement Program
DSHAP	HAB's Division of State HIV/AIDS Programs
EC	Emerging Communities
EHBs	Electronic Handbooks
EHE	Ending the HIV Epidemic in the U.S.
EIHA	Early Identification of Individuals with HIV/AIDS
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
ERF	ADAP Emergency Relief Fund or X09
FDA	Food and Drug Administration
FFR	Federal Financial Report
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GAO	Government Accountability Office
GCMS	Grant Contract Management System
GMS	Grants Management Specialist
GMO	Grants Management Officer
GPS	HHS Grants Policy Statement
HAB	HIV/AIDS Bureau
HHS	U.S. Department of Health and Human Services
HIVQM	HIV Quality Measures
HIT	Health Information Technology
HOPWA	Housing Opportunities for Persons with HIV/AIDS
HRSA	Health Resources and Services Administration
IHS	Indian Health Service

LPAP	Local Pharmacy Assistance Program
MAI	Minority AIDS Initiative
MCM	Medical Case Management
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
MSA	Metropolitan Statistical Area
NCC	Non-Competing Continuation
NMS	RWHAP National Monitoring Standards
NoA	Notice of Award
NOFO	Notice of Funding Opportunity
OAA	HAB's Office of the Associate Administrator
OFAAM	Office of Financial Assistance and Acquisition Management
OIG	Office of Inspector General
OMB	Office of Management and Budget
OOM	HAB's Office of Operations and Management
OPDIVs	HHS Operating Divisions
OPS	Office of Program Support
PB	Planning Body
PC	Planning Council
PCN	Policy Clarification Notice
PDSA	Plan-Do-Study-Act
PMS	Payment Management System
PO	Project Officer
PSRA	Priority Setting and Resource Allocation
PTR	Program Terms Report
PHS	Public Health Service
CQI	Clinical Quality Improvement
RFI	Request for Information
RFP	Request for Proposal
RSR	Ryan White HIV/AIDS Program Services Report
RWHAP	Ryan White HIV/AIDS Program
SCSN	Statewide Coordinated Statement of Need
SPNS	Special Projects of National Significance
TA	Technical Assistance
TAC	Technical Assistance Contract
TARGET	Technical Assistance Resources, Guidance, Education and Training
TGA	Transitional Grant Area
UAR	Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards
UOB	Unobligated Balance
WICY	Women, Infants, Children, and Youth