Monitoring Standards:
Frequently Asked Questions (FAQs) For Ryan White HIV/AIDS Program Part A and B Grantees

Table of Contents

National Monitoring Standards Basics

1. **What are the National Monitoring Standards for Ryan White HIV/AIDS Program Part A and Part B?**
   The National Monitoring Standards (Standards) are designed to help Ryan White HIV/AIDS Program Part A and B (including AIDS Drug Assistance Program) grantees meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness. Requirements set forth in other sources are consolidated into a single package of materials that provide direction and advice to grantees for monitoring both their own work and the performance of service providers. The Standards consolidate existing HRSA/HAB requirements for program and fiscal management and oversight based on federal law, regulations, policies, and guidance documents.

2. **Why were the National Monitoring Standards developed?**
   The Standards were developed by the Division of Service Systems (DSS) within the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB) in response to several Office of Inspector General (OIG) reports. These reports identified the need for *a specific standard regarding the frequency and nature of grantee monitoring of subgrantees* and a clear HRSA/HAB Project Officer role *in monitoring grantee oversight of subgrantees.*

3. **How were the National Monitoring Standards Developed?**
   The Standards were compiled by HAB/DSS with a national team of fiscal and program experts with assistance from a working group of Part A and B grantees who participated in a consultation in Washington, DC and provided feedback on drafts of the Standards.

4. **How will the National Monitoring Standards help grantees?**
   The National Monitoring Standards are designed to:

- Help grantees comply with federal requirements on proper use of federal grant funds, based on the Ryan White HIV/AIDS Program legislation, federal regulations establishing administrative requirements for HHS grant awards, Office of Management and Budget (OMB) principles, the HHS Grants Policy Statement, HRSA/HAB policies, the Notice of Award and Conditions of Award, and DSS program guidance.
- Meet grantee requests for clarity on HRSA/HAB expectations regarding the level, scope, and frequency of subgrantee monitoring.
- Provide a single document that includes the minimum expectations for both program and fiscal monitoring.
- Address concerns of HRSA, Congress and OIG regarding administrative oversight of Ryan White HIV/AIDS Program grantees and providers/subgrantees.
- Help streamline and standardize Project Officer monitoring and site visit functions.
- Enhance program compliance at the local, state, and federal levels – and reduce negative HRSA and OIG audit findings.
- Ensure proper stewardship of all grant funds and activities, whether carried out by the grantee or by a subgrantee provider; and
- Communicate applicable requirements to subgrantees and monitoring them for compliance.

5. **What entities are covered by the National Monitoring Standards?**
   The Standards cover "providers/subgrantees" – a category that includes all direct providers of Part A and B Ryan White HIV/AIDS Program funded care and treatment services, whether the health department or another local state or local agency, subgrantees, subcontractors, or consortia. The Standards sometimes reference federal regulations that refer to *contractors* in the broad sense – meaning any entity with which the grantee has a legal agreement – but they are designed specifically for direct service providers.

6. **Are professional and/or technical support subcontractors covered by the National Monitoring Standards?**
   No. They are *not* designed for use with subcontractors that provide professional or technical support (such as needs assessment or quality management). However, standards addressing Unallowable Costs and Financial Management apply to all contracting, regardless of purpose.

7. **What are the requirements that are included in the National Monitoring Standards?**
   The Standards are a compilation of requirements from many different sources. They are based on and refer to all of the following:

   - Title XXVI of the Public Health Service Act, 42 U.S.C. Section 300ff-11 et seq. also known as the Ryan White HIV/AIDS Program legislation
   - Code of Federal Regulations (CFR)

- Federal, Department of Health and Human Services (HHS), and Public Health Service grants management policies
- HRSA/HAB policies and guidelines
- Part A and B Program Guidance Documents
- Notices of Award and Conditions of Award *(which accompany the annual grant awards)*
- Office of Inspector General (OIG) reports and recommendations
- Manuals and guides issued by HRSA/HAB (such as the Part A Manual)

8. **Are grantees expected to comply with all of the standards?**
   Y*es. The standards,* as stated in the first column of each document, are established requirements, and HRSA/HAB expects grantees to comply with each of them.

9. **Are grantees expected to comply with the National Monitoring Standards in FY 2011?**
   Yes. HRSA/HAB expects the Standards to be effective immediately.

10. **What must the grantee collect to demonstrate to HRSA that it is in compliance with the Monitoring Standards?**
    Each standard lists the requirements needed to ensure compliance. They include actions and documents as proof of performance compliance. The grantee is expected to establish written tools, protocols, policies and procedures for conducting a monitoring visit. The procedures should describe the use of tools, protocols, and methodologies during the site visit; a report should be on file for every visit; and if needed, a corrective action plan should also be on file. The grantee must keep these documents available for the Project Officer or HRSA site visit team to review, in order to demonstrate compliance with subgrantee monitoring requirements.

11. **Do the National Standards address how much documentation should be sent in with monthly invoices?**
    No. The standards are not prescriptive on the amount or type of supporting information required for payment of monthly invoices. Regardless of whether the subgrantee is paid by expense categories (line items) or for reimbursable units of service, monthly invoices should be accompanied by sufficient supporting documents to determine if the expenses claimed: a) are for eligible clients, reasonable, and allowable under the grant; and b) can be used as suitable backup and auditable files. The monitoring site visit team should be able to review the source documents of paid invoices using the supporting documentation.

Back to top

Structure of the National Monitoring Standards Documents

12. **What is the scope of the National Monitoring Standards?**

There are three sets of standards:

1. **Universal Monitoring Standards** – covering both fiscal and program requirements that apply to both Part A and Part B

2. **Fiscal Monitoring Standards** – separate versions for Part A and Part B

3. **Program Monitoring Standards** – separate versions for Part A and Part B, with some specific ADAP components

Each set of Standards is divided into major sections designed to allow users to easily search for information by topic.

13. **Do the documents contain more than Standards?**
Yes. Each Monitoring Standard has related four components in addition to the standard itself. They include:

Performance measures and methods for determining whether the standard is being met – actions to take and data to collect and analyze.

Grantee responsibility for meeting each standard – suggested actions and data requirements for the grantee.

Provider/subgrantee responsibility for meeting the standard – suggested actions the provider/subgrantee should be expected to take and data to be collected and maintained.

Citations that provide the source for each standard – legislation, federal regulations, federal or HRSA/HAB policy, guidance – so users are able to find and review the source document that specifies the requirement.

14. **Can grantees develop their own ways to measure compliance with particular standards?**
Yes. The *measures and methods* provided in the second column identify expected means for determining and documenting compliance with the standard. Most grantees will use these recommended approaches and data, but it is possible that a grantee may identify alternative, but equally sound, ways to assess compliance with the standard.

15. **Is there flexibility regarding implementation of the National Monitoring Standards? Yes. There is flexibility in how to implement the monitoring standards, not in whether to implement them.**
The third and fourth columns describing *grantee* and *subgrantee/provider responsibilities* present sound practices and recommended approaches. In general, grantees and providers/subgrantees will need to implement some or all of these actions to ensure that the standard is being met; but the grantee has flexibility in deciding which of the recommended methods to use and what specific systems and actions to require from providers/subgrantees. HRSA expects all grantees to ensure that all standards are implemented.

16. **Are the source documents for the National Monitoring Standards online? The Sources include references to past Part A and Part B Guidances. Past Guidances do not usually remain available. As time passes, where can we find them?**

Yes. Please see the chart in Appendix 1 for the online locations of source documents referenced in the standards. The final Monitoring Standards reference the FY 2011 and FY 2012 Part A and Part B Guidances. Some of the source documents, including referenced Part A and B Guidances, assurances, and the Ryan White HIV/AIDS Program legislation are posted on the TARGET Center website (www.careacttarget.org). Fiscal documents such as the Code of Federal Regulations can be downloaded from the Government Printing Office at http://ecfr.gpoaccess.gov, and the circulars from the Office of Management and Budget (OMB) are at www.whitehouse.gov/omb.

17. **Will Program Monitoring Standards be developed for Minority AIDS Initiative (MAI? Or do these Monitoring Standards apply to MAI automatically?**
Yes. Part A and Part B Monitoring Standards apply to MAI funds received as part of Part A and Part B grant awards.

Back to top

Implementation of the National Monitoring Standards

18. **How will HRSA/HAB prepare for implementation of the National Monitoring Standards?**
HRSA/ HAB will prepare for implementation by training Project Officers to ensure staff familiarity with the Standards, supporting materials and methods to ensure compliance. Project Officers will contact grantees to gather information on monitoring systems and grantee processes for implementation.

19. **Are there expected actions Grantees should take to implement the Standards?**
Yes. Grantees are expected to take the following steps to implement the Standards:

- Review the Standards that apply to your program. If some are unfamiliar, go to the citation for more information.
- Share the Standards and supporting materials with program and fiscal staff that have monitoring responsibilities. Ask them to review the Standards and help plan for implementation and compliance.
- Sit down with staff to review current monitoring systems, procedures, and tools to see where the Standards are already being met and where changes are needed.
- Meet with legal, contracts, procurement, finance, and other government entities that have Ryan White HIV/AIDS Program responsibilities and familiarize them with the Standards.
- Decide how grantee and subgrantee responsibilities will be implemented based on the approaches specified in the Monitoring Standards. If you use alternative approaches, be sure they comply with the Standards.
- Review your Requests for Proposals (RFPs) and contract language to assure that they specify that services be provided and data collected and reported in accordance with Ryan White HIV/AIDS Program requirements.

- Begin integrating the Standards into your contracting and monitoring efforts and refining those efforts as needed to meet the Standards – changing RFPs, contracts, monitoring tools, site visit schedules and scope, etc., as needed.
- Hold meetings with providers/subgrantees to introduce the Standards and clarify compliance issues.
- Make the Standards easily accessible to your providers/subgrantees. Add a link to the Standards on your website.
- Fully implement any needed changes in your subgrantee monitoring and oversight policies, procedures and monitoring tools, and in your own fiscal and program management and reporting.
- If you have questions or concerns, contact your Project Officer.

20. **Will some grantees have to change their current systems to meet the requirements?**
    Yes. Implementing these Standards may require rethinking some long-used practices with regard to monitoring. If current tools and monitoring procedures do not permit you to meet the Standards, you need to modify those tools and procedures. Technical assistance is available through your Project Officer**.**

21. **Will HRSA make examples of other grantee's monitoring procedures, systems and tools available?**
    Yes. Over the next few months we will provide examples of monitoring tools from other Part A and B grantees. We will also discuss other monitoring systems in future training presentations and Webinars. In addition, grantees are encouraged to share information, best policies and procedures along with best practices by posting them on the TARGET Center.

22. **Does HRSA/HAB have any tips that can be used to make other decision-makers understand the importance of the monitoring standards?**
    Yes. It is helpful if decision-makers understand the consequences of not improving monitoring systems. These include penalties for unobligated balances resulting in reductions of future grant awards, possibility of internal or Federal audits discovering unallowable activities, and improper payments. In such circumstances, the funding must be repaid to HRSA with local or non-Federal funds.

23. **Are grantees expected to review all client records? What is a recommended sample size?**
    No. There is no expectation that all client records must be reviewed. A random sampling methodology should be established as part of the monitoring protocols. The sample size is not specified in the standards, because it depends on the size of the client population being sampled and on the number and complexity of the variables you are reviewing. For a client population of 50 or less, the norm is to review 100% of folders; 50% or less is acceptable for a population of 51-100. The percent to be sampled gets smaller as the population gets larger – from 10% for a client population of 500 or more to 3-5% for a client population of 1000+.

24. **One of HRSA's monitoring expectations is annual site visits. Is this a comprehensive site visit or will a desk review or other type of site visit suffices?**
    No. The standards require an annual comprehensive monitoring site visit as delineated in Section I.E. of the Part A and B Universal Standards. The visit must test compliance with Fiscal, Programmatic, and Universal Standards. Desk reviews and other types of visits have

proven ineffective in the past, according to Office of Inspector General (OIG) reports issued in 2004 and 2006 and in the 2009 report on "Grantees' Monitoring of Sub-grantees."

25. **Are all Ryan White HIV/AIDS Program Part A providers to receive a site visit annually or are grantees required to do visits annually based on predetermined criteria, i.e., amount of funding, providers issues etc.?**
    No, The Monitoring Standards require as a minimum an annual visit to all providers.

26. **Are desk audits necessary monthly?**
    The usefulness of desk audits and any timelines for their use are determined by the grantee. Desk audits are not addressed in the Monitoring Standards. Desk audits may not be used as a substitute for comprehensive annual site visits.

27. **What constitutes fiscal monitoring?**
    Fiscal monitoring activities ensure that Ryan White HIV/AIDS Program funds are used for approved purposes as summarized in the Part A and B Fiscal Standards and delineated in the Code of Federal Regulations (CFR), the Office of Management and Budget (OMB) circulars, the Ryan White HIV/AIDS Program legislation, the Part A and B Guidances, and any letter or Policy Information Notices (PINs) issued by HRSA. The main required activity is an annual grantee-monitoring visit to all subgrantees. The visits must be standardized through published fiscal monitoring policy and procedures, which should include: protocols for the visit; the use of a monitoring tool or guide; issuing a monitoring report for each visit that addresses required elements, including sub-grantee strengths as well as any compliance issues; and a corrective action plan for each compliance issue. Further, the grantee must follow through to ensure completion of the goals of the corrective action plan. (Standard 3; Section E, Universal Monitoring Standards)

28. **Is there an exemption for grantees that are also direct service providers?**
    No. A grantee that is also the direct service provider assumes both the grantee and the subgrantee/ provider responsibilities.

29. **Is there an exemption for Part A or B base programs that contribute to the state's ADAP.**
    No. If your ADAP program is funded not only with ADAP funds but also by Part B base funds and/or Part A funds, you must meet the standards and requirements for each funding source.

30. **Are grantee accounting department's best suited to perform a correct and accurate cost-benefit analysis?**
    No. Grantee accounting units can perform cost-benefit analysis **if** they are familiar with Federal Accounting Concepts and Standards on programs related to cost that Federal laws and regulations impose and with the Ryan White HIV/AIDS Program specific statutory limitations. Outside entities familiar with these concepts, standards, and Ryan White HIV/AIDS Program limitations may also be used.

Back to top

Universal Monitoring Standards Questions

31. **Can HRSA/HAB define "timely" reporting?**
    Yes. When "timely reporting" refers to mandated Federal Reports, it means by the HRSA due date. When it refers to subgrantees' timely submission of reports to the grantee, it means submission with enough time for the grantee to complete its reports. For example: subgrantees must submit invoices on a timeline that allows the grantee to pay those invoices and submit their Federal Financial Report (FFR) by the required HRSA deadline, i.e. within 90 days after the close of the grant year,

32. **Are there any differences in what is required (e.g., programmatic reporting) from professional service contracts and what is required from subgrants/subcontracts? According to federal regulations, these are treated differently.**
    Yes. Ryan White HIV/AIDS Program legislation provides for States (Part B) and planning bodies or CEO's (Part A) to allocate funds to allowable core medical and support services based on documented service needs. In turn, Part A and B grantees are responsible for disbursing the funds based on those service allocations/priorities, defined as the awarding of financial assistance to an eligible subgrantee. The financial assistance can be awarded through a contractual legal agreement. Federal regulations afford the same treatment to any provider receiving federal dollars for its services. The service provider can be a subgrantee, subcontractor, consortium, governmental agreement, or the lead agency that administers the program (often the health department). If you are both the grantee and a direct provider of services, you must meet both the grantee and the provider responsibilities.

    The Monitoring Standards were developed specifically to address subgrantees/subcontractors providing direct HIV/AIDS services. Contracts for professional services such as needs assessment or technical assistance are allowable as program and planning support activities but are not the focus of the Standards. However, standards addressing Unallowable Costs and Financial Management apply to all contracting, regardless of purpose.

33. **Is the chief elected official (CEO) always the mayor (Part A) or governor (Part B), who in turn designates the local or State health department as the funding recipient? Or, can we have another elected official or funding recipient?**
    No. The legislation states that for Part B, the funding must go to the State/Territory's chief elected official, who in turn designates a lead agency for the administration and implementation of the program. While most governors designate the State's health department, which is not universal. Section 2611 of the legislation specifies "The Secretary shall, subject to the availability of appropriations, make grants to States to enable such States to improve the quality, availability and organization of health care and support services for individuals and families with HIV/AIDS."

    For Part A, Section 2602(a) specifies that funding "shall be directed to the chief elected official of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals with AIDS" in the

Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA). In some areas, that would be the mayor and in others the county board of supervisors. Again, most but not all Part A CEO's designate their jurisdiction's health department to administer the grant.

34. **Does an agency that receives Ryan White HIV/AIDS Program funding have to be a Medicaid provider?**
    No. The Medicaid provider provision applies only to providers who provide services covered by Medicaid. The Ryan White HIV/AIDS Program legislation, Section 2604(g), describes these as "any such service that is available pursuant to the State plan approved under title XIX of the Social Security Act for the State."

35. **Can our Ryan White HIV/AIDS Program Part A program fund a medical transportation provider if the provider is not Medicaid certified?**
    If the Medical Transportation service the subgrantee is providing meets HRSA's definition for that service category and is covered by Medicaid because it also meets the State's Medicaid transportation requirements, then the provider must be a Medicaid provider and bill Medicaid for services performed to Medicaid-eligible individuals. On the other hand, if the service provided by the subgrantee complies with HRSA's definition of Medical Transportation but is not covered by Medicaid or does not qualify for Medicaid payment, then the subgrantee does not have to be a Medicaid provider.

36. **Is insurance status a client eligibility or payer of last resort issue?**
    Insurance status is both an eligibility issue and a payer of last resort compliance issue. Clients must be recertified every 6 months to establish eligibility for Ryan White HIV/AIDS Program services which includes checking for insurance or other third party payers such as Medicaid, Medicare and Medicare Part D. These actions help ensure Ryan White HIV/AIDS Program is the payer of last resort.

37. **Is the Ryan White HIV/AIDS Program grantee required to provide training on third party eligibility to all contractors or is it sufficient to have policies/procedures and contract language?**
    Yes. The grantee must do what is necessary to assure that its subgrantees/subcontractors are compliant with payer of last resort and program income standards. To be compliant, the subgrantee must be Medicaid eligible, verify insurance eligibility for all its clients, and bill third parties for all billable visits. The grantee has a duty to monitor its subgrantees for compliance, and if a subgrantee is found not to be compliant, to bring it into compliance, at which time technical assistance might be an option.

38. **Does eligibility training of subgrantees need to be done on a timeline, e.g. annually?**
    No. The frequency for training subgrantees regarding eligibility or any other compliance issue is at the discretion of the grantee. The annual monitoring of each subgrantee by the grantee for compliance with Part A and B eligibility determination/screening, as mandated in Section B of the Universal Standards is mandatory.

39. **Can client eligibility be confirmed by one Ryan White HIV/AIDS Program provider (e.g., case management, primary care) and have this suffice for all Ryan White HIV/AIDS Program programs the client uses, or must every program re-assess eligibility?**
    Yes – use of a single eligibility record is acceptable for both Ryan White HIV/AIDS Program Part A and B programs. The following criteria must be satisfied in order to use a single eligibility records: (1) Ryan White HIV/AIDS Program Part A, Base B, C, and ADAP must

have the same eligibility criterion that meets the requirements of all the titles (i.e., use the same percentage of federal poverty limit (FPL) to establish eligibility); (2) there must be an application with supporting documentation (i.e.. income and insurance verification); (3) the application and supporting documentation must be available for review at each of the providers' sites; and (4) the individual provider must be aware that the responsibility of providing allowable services to eligible clients still rests with the individual provider. The sharing of eligibility application and documentation can be done by copying the original application and documents or by electronic access to the application and documentation.

40. **If an agency provides multiple services, can an "eligibility record" be developed to provide the documentation for all the services?**
    Yes. An eligibility record can be developed so that once the agency deems the client eligible for Ryan White HIV/AIDS Program services the client can access any of the provider's services.

41. **Can a paperless system be used where source documents are scanned into a client database and made available for electronic review and allow us to document compliance with certain standards?**
    Yes. As long as the eligibility records are available for review at each provider site and eligibility requirements are not different from provider to provider.

42. **If eligibility is posted in a real-time online system, does that count toward an agency's determination of eligibility?**
    Yes. The information and documentation to establish eligibility must be available and scanned into the system as part of the patient record.

43. **Is there a grace/transition period for Ryan White HIV/AIDS Program clients that are no longer financially eligible?**
    No. Due to statutory requirements, the standards do not allow a grace or transition period for clients who no longer meet Part A or B financial eligibility criteria and/or become eligible for care under Medicaid, Medicare/ Medicare Part D, State programs or private insurance, e.g. through an employer. The provider is responsible for transitioning clients receiving medical services or medicines under ADAP to other services or resources if they are no longer financially eligible.

44. **Our State allows local consortia to set local Federal Poverty Level limits based on local conditions. Is this allowable under new rules setting "statewide, uniform" process and policy?**
    Federal Poverty Level (FPL) thresholds are set annually by the U.S. Department of Health and Human Services (HHS). The grantee reserves the right to set eligibility requirements for Ryan White HIV/AIDS Program clients. Therefore the practice can continue as long as each consortium has a written eligibility policy and procedure. The grantee is responsible for conducting an annual monitoring visit during the grant year and testing for eligibility based on the area's eligibility requirements.

45. **The standards mention a cap on services. Is this a new requirement?**
    No. Every service has limitations on what services are allowable under that service category, and some may have cost or level of service caps. These limitations are clear under each service standard, as is the flexibility of the Ryan White HIV/AIDS Program to set Standards of Care that include service caps. There are also financial limitations or caps in the legislation such as: the amount of funding that can be used for administration (10%) or

clinical quality management (5%) or in Part B for planning and evaluation (5% or aggregate of 15% for administration and planning). There are also income-based financial limitations on the amount of charges a client can be assessed in a given year before the Ryan White HIV/AIDS Program services are free for the remainder of the year. Service limitations are not a new requirement.

46. **Can HRSA/HAB explain the Department of Veterans Affairs eligibility process?**
The Department of Veterans Affairs (VA) manages its program through an annual patient enrollment system. The enrollment system assigns veterans to priority groups based on their service-connected condition, income, and/or net worth thresholds and geographical income thresholds. The groups range from priority 1, the highest, through priority 8. Veterans with a service-connected disability rating of 50% or more are assigned to Group 1and veterans who agree to pay specified copayments with income/and/or net worth above the VA Mean Test threshold and income above the geographically-based threshold for their locality area assigned to Group 8. In 2003, the VA stopped providing services to veterans in Group 8. For more information about the VA system, please see:
http://www.va.gov/healtheligibility/coveredservices/StandardBenefits.asp

47. **Will receiving treatment or services from the Department of Veterans Affairs result in a payer of last resort issue under the Ryan White HIV/AIDS Program?**
No. VA health care is not an insurance plan or an entitlement program, and the VA's authority to pay for services from non-VA providers is extremely limited by law. VA services do not meet the payer of last resort reasonable payment criteria given that the grantee cannot expect payment for the service from the VA. Therefore grantees may inform HIV-infected veterans of the benefits services, eligibility criteria, and the location of the VA facility in their service area, but cannot compel the client to seek services at the VA or refuse to provide services citing payer of last resort language.

48. **What are the Federal Poverty Guidelines and how do I find out about them?**
The Federal Poverty Guidelines are published by HHS and based on annual Census calculations as a way to estimate the number of people living in poverty in the United States. The HHS poverty guidelines provide income thresholds based on family size. (There are three separate thresholds for the 48 contiguous states, Alaska, and Hawaii.) They are revised every year in early spring and published in the Federal Register, and are available online at

http://aspe.hhs.gov/poverty/index.shtml

49. **Are we to use the new Federal Poverty Guidelines from 2011?**
Yes, the new guidelines were released in the spring 2011. No new guidelines were released for 2010; the 2009 guidelines were retained for use.

Back to top

Program Monitoring Standards Questions

50. **How should grantees ensure that allowable services are "related to HIV" as in the case of medical services? Where do you draw the line?**
Ryan White HIV/AIDS Program funding for outpatient medical care is clear on what is allowable. The grantee must provide comprehensive, coordinated primary HIV medical care, and this defines the types of office visits that are allowable under Ryan White HIV/AIDS Program. The main characteristic of primary care is that the patients consult their primary care doctor for routine check-ups and any time they have a new physical problem. Consequently, primary care practitioners treat patients seeking to maintain optimal health as well as those with acute and chronic physical, mental, and social health issues, including multiple chronic diseases. Chronic illnesses usually treated by primary care providers include: hypertension, heart failure, angina, diabetes, asthma, COPD, depression, anxiety, back pain, arthritis, thyroid dysfunction, and HIV. Primary care is inclusive of HIV, and proof of a relationship with HIV is not needed if these conditions are treated as part of routine primary HIV medical care. Where medical specialty care is required, Ryan White HIV/AIDS Program funding is provided only if the condition is related to the individual's HIV disease.

Availability of medications for chronic diseases is not a result of allowable vs. non -allowable costs, because Ryan White HIV/AIDS Program is prescriptive only about limiting the antiretroviral medications to those approved in the PHS Clinical Practice Guidelines.

51. **According to HAB/DSS' guidelines for early identification of individuals with HIV/AIDS (EIIHA), once the individual has been tested the provider can refer both HIV-positive and HIV-negative clients to care. Would the HIV-negative client be considered a Ryan White HIV/AIDS Program HIV/AIDS Program eligible client?**
No. EIIHA guidelines specify that an individual who tests HIV-negative should be referred to HIV prevention services. Generally, non-infected individuals are not eligible for HIV care services funded by the Ryan White HIV/AIDS Program except in limited situations, and the provision of services must always benefit a person living with HIV infection. HAB Policy Notice 10-02 describes the situations in which program funds and services can be provided to an individual who is HIV-negative.

52. **Are Consumer Advisory Boards required of all subgrantees?**
No. Consumer Advisory Boards are not a required mechanism for consumer involvement under Part A or B. However, a Consumer Advisory Board or Council that allows consumers to have a voice in the development and planning of the program is an optimal solution and is encouraged by the standards.

Fiscal Monitoring Standards Questions

53. **Does HRSA/HAB allow grantees and providers to allocate a percent (5-10%) of their Ryan White HIV/AIDS Program Part A and B funding for quality management staff and continuous quality improvement (CQI) activities, as is permitted for Ryan White HIV/AIDS Program Part C?**
No. The Ryan White HIV/AIDS Program legislation limits Part A and B funding for quality management activities to 5% of the total grant award or $3 million, whichever is less. There is no such limitation for Part C or D. (See the Ryan White HIV/AIDS Program legislation,

Part A, Section 2604(h)(5) and Part B, Section 2618 (b)(3)(E)(i-ii)).

54. **How does an agency obtain a HRSA-approved indirect cost rate?**
The Division of Cost Allocation in HHS negotiates and approves indirect cost agreements for entities receiving funding through the Department. This Division negotiates rates through its four regional field offices and the national headquarters. To obtain information from one of these offices go to: http//rate.psc.gov and click on Contact Information, then click on the appropriate link: National Headquarters, Western, Central States, Mid-Atlantic, Northeastern. Contractors and subcontractors wanting to claim administrative costs in their Ryan White HIV/AIDS Program budget as indirect costs are allowed to do so only (1) with an HHS-approved indirect cost rate in accordance with applicable cost principles; and (2) in accordance with the 10% legislative limitation on administration costs, (i.e., indirect costs are included in the definition of grantee administration under Part A and B, as mandated by the legislation).

55. **Are subcontractor expenses for "rent, utilities etc." an allowable direct service expense?**
No. Subcontractor/subgrantee expenses for rent and utilities are allowable direct and/or indirect ***administrative expenses*** within the 10% aggregate limitation on administrative costs. Rent is included in the accounting definition of "overhead". Overhead is the ongoing administrative expenses of operating a business (also known as operating expenses – rent, gas/electricity, wages, etc.) Rent is considered an overhead expense, and under Ryan White HIV/AIDS Program guidance, subcontractor overhead expenses are considered to be administrative costs.
****These costs may not be shown as direct service expenses.***

56. **What are the indirect cost documentation requirements for the grantee and subgrantees?**
Grantees and subgrantees wanting to claim indirect cost rates in the program budget must have a Negotiated Indirect Cost Rate Agreement with the HHS Division of Cost Allocation. Grantee indirect costs must be applied to the 10% administrative limitation, while subgrantee indirect costs must be included in the 10% aggregate administration limitation for subgrantees.

57. **Do very large institutions that routinely provide/conduct annual OMB A-133 audits need/require a single point audit of all Ryan White HIV/AIDS -funded programs?**
Yes. OMB A-133 circular requires a Single Point audit of any program that receives more than $500,000 in aggregate federal funding. Therefore, the agency's audit should be inclusive of the Ryan White HIV/AIDS Program. It is advisable for large institutions with a small Ryan White HIV/AIDS Program subgrant to request that the auditors occasionally make the Ryan White HIV/AIDS - funded program a part of their sample.

58. **Do fiscal monitoring requirements apply to performance-based contracts where the basis of payment is reported services, not expenditures?**
Yes. Regardless of the type of contract or reimbursement preference, the grantee is mandated to monitor for compliance with Federal requirements and programmatic expectations. In the case of performance-based contracts, the source documentation and selected testing procedures might be different, but the mandate remains the same: to ensure that the delivered service is provided utilizing appropriate cost principles and the

amount charged is reasonable. In addition, the Ryan White HIV/AIDS Program is a cost-based reimbursement program, and the grantee is required to perform an annual reconciliation of the amount charged for the service with the actual cost of delivering the service.

59. **Do the National Standards cover the requirements for implementation of legislative limitations on annual charges?**
Yes. The Ryan White HIV/AIDS Program legislation requires that individuals be charged no more than a maximum amount in a calendar year according to the following criteria:

- If an individual's income is less than or equal to 100% of the Federal Poverty Level (FPL), the individual may not be charged for services.
- For individuals with income from 101% to 200% of the FPL, cumulative charges in a calendar year can be no more than 5% of the individual's annual gross income.
- For individuals with incomes from 201% to 300% of the FPL, cumulative charges in a calendar year can be no more than 7% of the individual's annual gross income.
- For individuals with income over 300% of the FPL, cumulative charges in a calendar year can be no more than 10% of the individual's annual gross income.

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 grantee or its subgrantees. The legislation explicitly refers to enrollment fees, premiums, deductibles, cost sharing, co-payment, coinsurance, or similar charges.

60. **Is it the grantee's responsibility to track annual client charges from multiple providers?**
No. It is the client's responsibility to track charges. To meet the legislative requirements on limitation the grantee and subgrantees are required to:

- Verify annual income,
- Determine what a client's cap on charges should be,
- Monitor charges made to clients for all HIV services performed by all providers, and
- Change the billing status to "no charge" when the cap is reached.
- Clients are responsible for saving receipts and bills to document payments for services. It is the responsibility of the grantee to review this documentation to ensure that Ryan White HIV/AIDS Program clients are not charged more than the legislatively specified cap on charges.

61. **Is there a difference between the sliding fee and the limitation on annual client charges?**
Yes. According to the legislation, the sliding fee or discount on charges is different from setting a limitation on the total charges a client can be required to pay in a given year for HIV services (Ryan White HIV/AIDS Program funded or other), before Ryan White HIV/AIDS Program services are provided free for the remainder of the year. The legislation makes subgrantees or providers of services responsible for tracking not only the charges in their program or clinic, but also the charges made outside their program or clinic, such as hospital or pharmacy charges.

62. **Do the National Standards contain recommendations on how subgrantees can track patients' charges*?***
Yes. Some of the ways subgrantees can track patients charges include:

- Maintain a running total of what the program billing office and front desk have charged each patient for HIV services.
- Develop spreadsheets or small databases to maintain this information.
- Develop systems that show verified income, automatically compute sliding scale fees and or discounts, and automatically track progress toward meeting the cap.

63. **Does the subgrantee track charges made by other providers?**
No. It is the responsibility of the client to provide receipted bills to demonstrate payments to other providers.

64. **Are some services, for example medical case management, exempted from imposing charges under the sliding fee scale?**
No. The legislative requirement applies to all services for which the agency imposes a charge. If the agency has charges for case management because they are billable to Medicaid, the agency may impose the same charge and provide a discount to uninsured clients using case management services.

65. **Do Ryan White HIV/AIDS Part A, B, and C Programs give different guidance on how income is calculated for sliding fee scales (individual vs. household) or on Ryan White HIV/AIDS Program sliding fee requirements?**
No. The sliding fee requirements for Part A, B, and C are the same. Ryan White HIV/AIDS Program-eligible individuals with incomes less than or equal to 100% of the Federal poverty level are not charged or required to pay any optional nominal fees. Individuals with incomes above 100% of the Federal poverty level are charged a discounted rate or a nominal fee so long as the charges do not exceed the limitations based on income mandated by the Ryan White HIV/AIDS Program legislation (cap on charges). Part A and B programs often ask for family income, which must be assessed using the same Federal Poverty Level criteria, but based on the number of individuals in the family.

66. **If a Part B provider also receives Part C and Part D funding and the client is effectively enrolled in all three parts, which program collects the sliding fee?**
The agency /program collects the fees based on the services rendered at the time of the visit, regardless of the funding source. The total program income (collected fees) can for the purpose of reporting be apportioned directly or indirectly by formula.

67. **What is the difference between program income and reimbursement?**
    Reimbursement is the third party payments made by insurance companies for medical treatment or procedures.
    Program income is a payment or 'reimbursement' derived from an activity or service funded by Ryan White HIV/AIDS Program, such as 340B drug rebates and sliding scale fees or other client cost-sharing payments. Program income remains with the subgrantee; but it must be tracked, added to resources committed to the project or program, and used to further the eligible project or program objectives and/or to cover program costs.

68. **What types of activities can be paid for with program income? What level of detail is required**?
    Program income can fund any activities or costs associated with the provision of services at a Ryan White HIV/AIDS Program-funded program. Program income is not considered Federal funding and therefore is not subject to Federal regulations. Activities that can be funded by program income include administration, continuous quality improvement; support and core services.

69. **Is there a better way to establish maintenance of effort (MOE)? Specifically determine which service categories to base the MOE on?**
    Yes. The Ryan White HIV/AIDS Program legislation is very explicit on how to establish MOE and which service categories are parts of the MOE. The Part A and B assurances state that "The Maintenance of Effort provision of the legislation requires that grantees maintain year to year HIV related core medical and support service expenditures by political subdivision within the eligible area." The grantee is required to maintain systems that use clear reporting methodologies that consistently track and report grantee MOE expenditures year to year. The Guidance provides a worksheet for the reporting of MOE expenses. The worksheet should be supported by documentation that can easily be examined by HRSA.

70. **Is there a standard fiscal assessment report (tool) for fiscal monitoring visits that HRSA requires the grantee to use?**
    No. There is no standard fiscal or program assessment tool or report.

71. **Is there a standard regarding administrative burden for reporting and documentation requirements?**
    No. Administrative activities under Ryan White HIV/AIDS Program are capped at 10%. The Monitoring Standards are not a new requirement; they bring together existing requirements from multiple sources. The compliance (monitoring) visits to subgrantees should already be taking place, and the documentation and reporting requirements should be the same unless compliance requirements were not being fully met.

Appendix 1

Source	Available Online:

Ryan White Treatment Extension Act of 2009	2006 legislation: http://hab.hrsa.gov/abouthab/legislation.html http://thomas.loc.gov/home/gpoxmlc111/s1793_enr.xml
Code of Federal Regulations (CFR) and other federal, Department of Health and Human Services, and Public Health Service-specific grants management policies	Searchable listing: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl OMB Circulars in numerical sequence: http://www.whitehouse.gov/omb/circulars_default
HRSA/HAB DSS Policies	Policies from 2001 forward, including policies updated in 2010 http://hab.hrsa.gov/manageyourgrant/policiesletters.html
Manuals and other policies, expectations, and guidance issued by HRSA/HAB	Part A Manual (online update, 2009) http://hab.hrsa.gov/Resources/partamanual/index.html Part B Manual (2003) http://hab.hrsa.gov/Resources/partbmanual/index.html ADAP Manual (2003) http://hab.hrsa.gov/Resources/adap/section5part1.html
Conditions of Award	Conditions of Grant Award accompany Notice of Award Assurances are an appendix to each year's Program Guidance Funding Opportunity
Office of Inspector General (OIG) report	OIG Report: The Ryan White CARE Act Title I and Title II Grantees' Monitoring of Subgrantees, March 2004: o http://oig.hhs.gov/oei/reports/oei-02-01-00641.pdf

Back to top