BOSTON PUBLIC HEALTH COMMISSION

2025

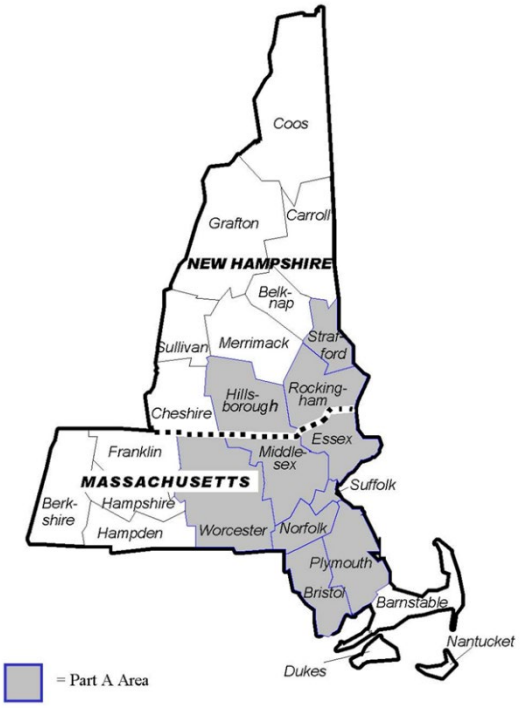
Ryan White HIV/AIDS Treatment Extension Act Part A

Boston Eligible Metropolitan Area

Provider Manual

Fiscal Year 2025

March 1, 2025 - February 28, 2026



BOSTON PUBLIC HEALTH COMMISSION

INFECTIOUS DISEASE BUREAU

RYAN WHITE SERVICES

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Table of Contents

Introduction

The Ryan White HIV/AIDS Program (RWHAP) began in 1990 and since then, the Boston EMA has provided funding and services to people living with HIV. RWHAP is the most extensive Federal program directed exclusively toward providing core medical and support services to people living with HIV. The goal of RWHAP is to improve HIV-related health outcomes, increase viral suppression, and reduce HIV transmission. The Ryan White Services team currently funds 11 core medical and support services.

We are proud to have been a part of the National Ryan White HIV/AIDS Program throughout the 35 years in which it has been in operation. The Ryan White Part A program in the Boston EMA serves clients at 32 agencies across 10 counties in Massachusetts and New Hampshire. It is highly effective, serving over 5,000 clients, and achieving a 91% viral suppression rate.

The FY25 Provider Manual is updated from previous iterations and includes guidance, policies, and protocols related to Ryan White services, grants management, and fiscal management. Please feel free to contact our team at any time with questions or feedback on this document. We will update the manual as needed throughout the year.

We deeply appreciate the dedication, creativity, and innovation that providers across the Boston EMA have demonstrated to ensure critical services for people living with HIV. We look forward to working with you in new ways over the coming year. It is an honor to be your partner in eliminating new HIV infections and ensuring that PLWH has the opportunity to maximize their health and well-being.

Sincerely,

Ryan White Services

Boston Public Health Commission

Please review: This Manual is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $15,243,837 with 0 percent financed with non-governmental sources. The contents are those of the Ryan White Services and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Program Reporting Rules FY 2025

Reporting, as outlined below, is a mandatory deliverable within the Ryan White Part A scope of work. Failure to produce timely and adequate reports may jeopardize the subrecipient's eligibility or consideration for funding in subsequent years.

1) The subrecipient must maintain a record of participating Part A clients in BPHC's e2Boston System. Subrecipients must register all clients in e2Boston, including information regarding their demographics, exposure category, diagnostic information, housing and insurance status, and medical history**. Every month**, the subrecipient must enter utilization data for each client, including units of service delivered, dates of service, and the number of units.
2) The subrecipient must complete an Outcomes Reporting to quantify and track the health of each client served. See Outcomes Reporting.
3) Subrecipients must notify Ryan White Services (RWS) of updates to their annual scope of work.
4) Subrecipients must report changes to primary Ryan White Part A program contacts to their assigned contract manager as soon as possible, and **no later than, within a month** of the change.
    a. If a subrecipient receives Medical or Non-Medical Case Management and Psychosocial Support Services, they must report changes in their case management and psychosocial support staff to the Case Management Training Program, and Psychosocial Support training and ensure the staff attends the required trainings. Subrecipients should contact their contract manager with any questions.
5) All subrecipients must complete the Ryan White Services Report (RSR) each calendar year. RWS will release additional information in January 2025 before the RSR submission. See the Ryan White Services Report.
6) All subrecipients must comply with the requirements detailed in the Ryan White Service Standards.

Reporting Due Dates

Submission	Reporting Period	Due Date
Invoices and Service Data Entry Submission of Fiscal Invoice and Client Utilization Data	Mar 1, 2025 - Feb 28, 2026	30 days after each month's end Apr 30, 2025 – Mar 30, 2026
Deadline for Audit Submission	Mar 1, 2025 – Jun 30, 2025	June 30, 2025
Deadline for Final Budget Revisions	Mar 1, 2025 – Dec 15, 2025	December 15, 2025
E2Boston Medical Outcomes Reporting	Mar 1, 2025 - Feb 28, 2026	MCM & NMCM providers must enter client Medical Outcomes into e2Boston within 60 days of each intake or reassessment (i.e. every six months).
E2Boston Quality of Life Outcomes Reporting	Mar 1, 2025 - Feb 28, 2026	All providers must enter client Quality of Life Outcomes into e2Boston within 60 days of the annual eligibility certification (i.e. every twelve months).
Completion of (4) four credits in IHI Open School	Mar 1, 2025 – Feb 28, 2026	February 28, 2026
HRSA Ryan White Services Report (RSR-Client Level Data)	Jan 1, 2025 – Dec 31, 2025	TBA

Program Performance

The Boston Public Health Commission reserves the right to suspend, reduce, or terminate the subrecipient's contract if it determines the subrecipient has failed to make substantial progress on its goals and objectives, that such failure is unreasonable, and if the subrecipient does not demonstrate an adequate strategy to address obstacles to that progress.

RWS will assess subrecipient program performance through monthly calls, annual site visits, and ongoing monitoring and review of the following:

1) Program utilization and spending
2) Compliance with the program, data, and fiscal requirements
3) Demonstrated efforts to link and retain clients in care
4) Client outcomes

Client Eligibility

The Eligibility requirements for a client under the Ryan White Grant include:

1) Confirmed HIV (+)/AIDS diagnosis
2) Income Eligibility
3) Residency within the Boston EMA
4) Insurance Verification

The subrecipient must comply with the Financial Eligibility Policy for Ryan White Services which requires funded subrecipients to **screen HIV+ clients** for **income eligibility,** based on a threshold of **500% of the Federal Poverty Level (FPL)** as determined by the U.S. Department of Health and Human Services (HHS). Subrecipients must document client eligibility annually to assess changes to client eligibility. See the Policy Clarification Notice 13-02 for more information.

Guide to Collecting Eligibility

Programs must maintain an on-site record for each client receiving Ryan White services, which includes the following documentation. Please refer to the Boston EMA's FY 25 Service Standards for more detail. Sample Forms provided for Eligibility Exceeding Charges and No Income.

Eligibility Form	
HIV VERIFICATION	Programs must have documentation of each client's HIV* status. Examples include: • Provider statements acknowledging HIV status • Labs** **HIV Verification only needs to be collected once upon intake. The remaining verifications are required to be updated annually.* ***Upon initial intake, if the client has an undetectable viral load, we suggest having their provider write a note on/ with their lab results confirming HIV diagnosis.*
INCOME VERIFICATION	Programs must have documentation of each client's income. Examples of documentation include: • Benefits statements • Pay stubs • MassHealth Eligibility verification • A written letter signed by the client attesting to no income. *Client household income must be less than or equal to 500% of the Federal Poverty Level (FPL) to receive Part A services.*
RESIDENCY VERIFICATION	• Proof of residency can be in the form of: • Driver's license. • Utility bills. • Bank statement. • Real estate tax bill or receipt. • Current residential lease. • Paycheck or benefits statements. • A written letter signed by the client attesting to residency.
INSURANCE STATUS	Programs must have documentation of each client's insurance status. Types of insurance coverage can include public (Medicare, Medicaid/MassHealth,

	Commonwealth Care), private (employer-based, private non-group, COBRA, or subsidized individual plans via Commonwealth Choice), or other types of coverage (VA Benefits). If a client is not eligible for any existing insurance plans, then the provider should document the reason and how the client will access medical services and prescription drugs.

Annual Site Visits

Each Ryan White Part A subrecipient is required to participate in an annual comprehensive site visit. RWS conducts site visits to determine subrecipient compliance with contractual obligations, program policies, Service Standards, and Ryan White HIV/AIDS Program Federal legislation. The following summarizes what to expect during an annual site visit.

Scheduling

Subrecipients will receive 30-45 business days advanced notice of a scheduled site visit. A contract manager will notify the subrecipient's Executive Director and main the program contact listed in RWS's records. If the assigned date is not feasible, the subrecipient must respond to RWS as soon as possible via email to notify the contract manager of the need to schedule the site visit for a different date and provide a justification for the need to reschedule. RWS will attempt to accommodate subrecipient schedules as best as possible but reserves the right to visit a funded subrecipient at a time of our choosing and without advance notice.

Before the site visit, an assigned RWS contract manager will email the subrecipient a confirmation packet. The contract manager will be the point of contact throughout the entire site visit process.

The confirmation packet includes the following items:

- Site visit confirmation letter with the date and time of the site visit
- Monitoring Tool
- Client File Review Worksheet

The contract manager will also schedule **a pre-site visit call** to review the agenda, answer any questions on the confirmation packet, provide client codes, and general site visit preparation and logistics.

Monitoring Tools

RWS staff utilizes a standard monitoring tool to evaluate subrecipient compliance with Ryan White Part A contractual obligations, policies, and standards. Subrecipients are responsible for completing a portion of the monitoring tool **one week before** the site visit.

The notification to confirm the scheduling of the site visit will include instructions and a due date for completing relevant sections of the monitoring tool. An RWS contract manager may schedule a call to review the information that is requested.

The monitoring tools comply with the National Monitoring Standards. Subrecipients are required to review the National Monitoring Standards annually or when changes are made. As a reminder any requested policies out of the National Standards are within the Boston EMA Service Standards. It is the **responsibility of the subrecipient** to review the changes to the Service Standards, in advance of the visit, to ensure that all policies and procedures are created and implemented successfully.

Client Charts

24-72 hours before the site visit, RWS staff will send the subrecipient an email with the pre-site visit call agenda. The agenda will include a list of randomly selected client codes. Depending on the total number of clients served at the agency and the number of services, the number of charts will be between a minimum of 12 to a maximum of 25 client charts. The subrecipient must pull these client charts for RWS review during the site visit.

All information pertinent to the services said client accessed must be present at the beginning of the site visit day. If there is a measure not found within the chart review, the team will not review it subsequentially which may result in an outcome during the exit conference.

If outcomes and site visit reports, note a request for a supplemental visit to review client chart compliance, the contract manager will collect a new randomly selected group of clients to review.

Federal Requirements

Monitoring visits are conducted according to uniform grant guidance for monitoring and evaluating federally funded programs. Much of this language is included in Part A contracts and subrecipients are required to review before signing their contract. Program staff can prepare for monitoring visits by familiarizing themselves with the Service Standards, Provider Manual, National Monitoring Standards, and core concepts of grants management and responsibilities. It is the responsibility of the subrecipient to ensure that all staff are trained on the appropriate requirements and rules under Part A. BPHC will provide Technical Assistance through the grant cycle to aid subrecipients in meeting compliance. See the Technical Assistance section for more information.

Day of the Monitoring Visit

The site visit will consist of the following activities:

1) Entrance Conference: At the beginning of the site visit, BPHC will meet with subrecipient staff to discuss timeline and expectations for the day. During this time, subrecipients may share any success and challenges of the program since the last visit, and any areas of Technical Assistance requested.
2) Chart Review: The site visit review staff will review a random sample of **up to 25 client records** to determine subrecipient compliance with contractual policies and service standards. Subrecipients will receive the client codes, along with the agenda during the pre-site visit call. RWS will not remove client records from the premises. Please ensure all client charts have the

appropriate Release of Information (ROI), and Funder Review forms up to date to allow the monitoring team the consent to review.

3) *Optional** Facility Tour: RWS may request a tour of the facility/or area where specific services are conducted.
4) Fiscal Review: Fiscal staff will review financial records and policies for compliance with contractual policies and federal legislation. **This review is not an audit.**
5) Policies Review (Program and Fiscal): Staff will review and test subrecipient policies for compliance with contractual obligations, federal legislation, and service standards. All policies required are listed in the **monitoring tool**.
6) Staff Interviews: The monitoring team will interview subrecipient staff to discuss their roles in providing Part A services and deepen their understanding of service implementation.
7) Exit Conference: RWS will discuss all outcomes with subrecipient staff at the end of the site visit.

Program staff **must reserve space** at the agency that can accommodate the RWS monitoring team **for the whole day**. During the exit conference, the site visit lead will discuss the outcomes and any next steps.

Site Visit Report

Subrecipients will receive a summary of the site visit in the form of a site visit report within **45 business days** of the completion of the site visit. This summary will include fiscal and programmatic outcomes that are identified based on areas that were identified as out of compliance with legislative and programmatic requirements. It may also include suggestions, which may not necessarily be a compliance issue, and/or an efficacious practice that the team would like to praise.

Your agency may be required to submit a Corrective Action Plan (CAP) that addresses the findings of non-compliance within 45 business days of receiving the official site visit summary. BPHC staff will provide technical assistance to programs to support compliance. See the Correct Action Plan section below for more information.

Depending on the outcomes of the visit, there may be a request to have a supplemental visit to ensure compliance improvements or a contingency for immediate correction to avoid payment suspension. If one of the above scenarios occurs, all details will be explained within the conclusion section of the report.

Types of Outcomes

Findings

Findings are legislative or programmatic based on Title 26 of the Public Health Service Act, Health Resource and Service Administration (HRSA), and Boston EMA's FY 25 Service Standards. Findings are reviewed as required items that are:

1) Not presented within the visit day
2) Does not align with current guidelines, whether in practice or policy

Findings must be completed promptly. If findings are not addressed in a reasonable timeline, or not sufficiently addressed, RWS reserves the right to assign the program a Corrective Action Plan (CAP) to enforce the completion of the outcomes.

Reports of findings include a reference that describes the source of the funding requirement with which the subrecipient is out of compliance with corrective actions to address the compliance issue.

Recommendations

The site visit review team may offer other recommendations related to best practices and suggestions for ways to enhance program operations, increase program efficiency, and/or improve program effectiveness. Recommendations **must be completed** by the end of the fiscal year, however, can be completed after the resolution of findings, if given, as those are the critical priority areas needed to be completed as soon as possible.

Observations

RWS may note an observation during the visit. This can be a general trend, positive or improvement areas, that was reviewed during policy and/or procedure review. The team may deliver this observation during the exit conference; however, it is not punitive and is intended to provide agencies with opportunities for quality improvement or additional internal review.

Corrective Action Plan (CAP)

RWS will require the submission of a Corrective Action Plan (CAP) **within 45 business days** of receipt of the written site visit report that issues 10 findings. Per HRSA TA, findings based on policies do not need to be assigned a CAP. Findings addressing eligibility or critical procedures that conflict with HRSA guidelines should be assigned corrective action.

RWS staff are available to assist agencies during the development of the CAP. Once BPHC approves the CAP, RWS staff will monitor the progress of the plan and support the subrecipient to achieve compliance before the next site visit. RWS may deny a CAP submission and request a revision.

If RWS rejects a CAP, the subrecipient must revise and resubmit the CAP **within one week** of the denial.

Technical Assistance

All subrecipients can request Technical Assistance (TA) at **any time** from their assigned contract manager. Contract managers will notify appropriate staff at a subrecipient site if the agency is out of compliance with programmatic or fiscal requirements, and it is recommended the notified staff attend any subsequent TA session. Both program and fiscal coordinators may support subrecipients in providing real-time training on HRSA and/or BPHC requirements, as well as provide resources and external training to further support staff. BPHC staff may also coordinate a workshop amongst providers funded under the same services for a best practice review, information session, or general Questions & Answers (Q&A).

Fiscal Reporting Rules FY 2025

All Part A contracted subrecipients are expected to expend 100% of their award following all federal, local, and BPHC policies. The Recipient will only pay subrecipients for deliverables that have been mutually agreed on (see Scope of Services and Budget) and upon receipt of invoices and appropriate backup documentation. If the subrecipient wishes to revise the Scope of Services or allowable costs, they must submit a proposal to revise the Scope and/or Budget. Failure to meet these expectations may result in suspension or termination of your contract.

Invoicing

General Information

1) A standard BPHC invoice template, including the approved budget summary and monthly expenses must be submitted. Part A payments are based on the approved budget, and only line-item budgeted expenses will be paid.
2) BPHC only accepts electronic invoices; handwritten invoices are not acceptable.
3) Each funded service must have their invoices signed by a program representative or a contract specialist before submission to BPHC.
4) Invoices are submitted monthly, within 30 days of the month's end. Each day after that will be considered late, therefore non-compliant. The final invoice for FY25 must be submitted no later than **March 30, 2026**.
5) Invoices must represent actual monthly expenses. Invoices without the required information or documentation (including required data and reports) will be rejected for resubmission.
6) If no contracted activities occurred in a given month, and there are no billing costs, the subrecipient **must** submit an invoice with a $0 monthly total for that month.
7) Any revised or supplemental invoices are to be clearly labeled as such by including the word "**Revised**" or "**Supplemental**" within the "Invoice Number" notation. Retroactive billing may only occur when the expense is not billed to another funding source. Documentation of bills to other funding sources may be required.
8) Monthly invoices containing all the required information will be paid within 30 days of receipt. **Invoices are sent to IDBinvoices@bphc.org.** When submitting invoices, please also copy the BPHC program coordinator for your agency.
9) For additional questions regarding the submission of invoices, contact your fiscal coordinator.

All subrecipients must meet the invoicing requirements outlined below, as determined by BPHC based on their Single Audit Report and/or Financial Statement Audit Report with Management Letter. Subrecipients should refer to the **RW Subrecipient Invoice Guide** for further details on invoicing (see the policy section for the RW Subrecipient Invoice Guide).

Personnel Expenses and Other Direct Care Costs Invoicing

1) Appropriate supporting documents for monthly staff expense invoices include:
    a. Payroll registers and labor distribution reports
    b. Copies of vendor invoices
    c. Canceled checks

d. Copies of reimbursement/voucher forms

2) The budget on the invoice must illustrate the **approved contract budget**. The monthly costs are charged on the invoice "Amount this Invoice" column. The "Cumulative Billing" column must correctly report the year-to-date billed amounts (including the current month's billing).
3) The fringe rate must be the internally audited fringe rate. Verification of this rate is subject to audit. (Fringe is defined as government- mandated and employer- selected employee benefits including Social Security, unemployment, workers' and disability compensation, retirement programs, and health insurance).
4) The following are requirements for invoices submitted for the payment of client-related travel, food/bank home-delivered meals, and other client consumables in the "Other Direct Care Cost" line items on any Part A budget:
    a. Itemized receipts if applicable must include the merchant or provider name, service received, or specific item purchased, date of service, and amount of expense.
    b. Itemized list indicating the client codes of those receiving the service and service utilization information (i.e., the dates and quantity of service provided to each client).
    c. Receipts for all expenses must be kept on file at the subrecipient and made accessible for review during the annual site visit monitoring for compliance purposes.

These services require the collection of documentation at the time of billing for all (but not limited to) the following 'Other Direct Care Cost' line items:

- Bus and subway fare
- Commuter rail
- Contracted services rides
- The Ride tickets
- Taxi vouchers
- Volunteer mileage
- Emergency Financial Assistance

Sample of the itemized list for **transportation** and **housing assistance** services:

Client Code/ UCI	*Date*	*Unit of Service*	*Amount*	*Vendor*
MAR0609547899/ RSCR0609542	03/04/25	Rental Start Up	$300	Century 21
MAR0609547899/ RSCR0609542	03/12/25	One-Way Taxi to Medical Appointment	$22.50	Boston Taxi

Please note:

- RW funds cannot be paid directly to clients.
- RW Part A Rental Assistance funds cannot be used for mortgage payments.
- The itemized lists for Transportation must include the to and from location and the purpose of the trip.

5) The following must be submitted before billing for a consultant the first time:
    a. A resume and list of qualifications for the consultant.
    b. A detailed description of the services/activities performed by the consultant.
    c. The consultant's last name must be indicated on the invoice cover sheet when the invoice is submitted.

6) RW Part A budgets can only include an "Indirect" line item (capped at 10% to ensure adherence to HRSA's current requirement) if the subrecipient has a certified HHS-negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certification of Indirect Costs. If the subrecipient has never before had a negotiated indirect cost rate, the subrecipient may utilize the de minimis rate, up to the 10% cap noted above. Subrecipients using administrative costs, which may include but are not limited to indirect costs must still adhere to the current 10% cap. Administrative costs used in subrecipient budgets must be itemized.

    a. **Please Note**: The calculation of administrative costs is not related to the de minimis indirect costs rate. The de minimis indirect cost rate may be used by any non-federal entity that has never received a negotiated indirect cost rate. The de minimis rate must only be used to pay for overhead costs that are not directly charged to federal awards. If all costs are charged directly to the federal award (e.g., space costs, utility, and administrative costs), then the subrecipient should not also charge the de minimis rate. When applying the de minimis rate, costs must be consistently charged as either direct or indirect costs and may not be double charged or inconsistently charged as both. The de minimis rate does not require documentation to justify its use.

7) Vehicle mileage is reimbursed at a per-mile rate not to exceed the Internal Revenue Service's standard mileage rate, which is currently **$0.70*** per mile**.**

8) Travel outside of the EMA is an allowable expense under Part A, especially when the travel is for necessary training, which may be held in various parts of the state or the country. Prior approval from the HIV/AIDS Services Division for travel outside of the EMA may be required under certain circumstances. **No international travel is allowed under this grant.**
    a. **Please note**: Tipping related to travel expenses (clients or staff travel) is an allowable expense, but only if it is part of a subrecipient's policies and procedures. The limits for tips are capped at 15%.

*Subject to change during the fiscal year. Pending reduction approval from HHS.

Budget Terms

Budgets cover twelve months and are presented in whole dollars (no cents).

Payment of expenses

1) The ***Core/Support Service Direct Cost*** column indicates the position title.
2) The ***Personnel*** column indicates the name of the staff person occupying the position with the staff's first initial and last name (e.g., J. Smith) to verify expenses. Enter ***TBH*** if the position is currently vacant. Program administration positions are funded, but only if their primary focus is the proposed service. Ryan White's direct services dollars are not to be used to pay for the subrecipient's administration.

3) The ***Salary*** column reflects a Full-Time Equivalent (1 FTE total) salary.
4) The ***FTE*** column is the percentage of time (carried to no more than **two** decimals) that the position listed is paid for by Ryan White Part A funding. To meet audit requirements, employees cannot exceed a total FTE of 1.0 across all funding sources.
5) The ***Months*** column is the number of months the position listed will be occupied in the contracted period.
6) The ***Annual*** column is the total salary amount that will be paid by Ryan White Part A in a twelve-month budget period for the listed position based on the given ***FTE*** and ***Months***. **Annual = (FTE x Months x Salary)/12**
7) The ***Fringe rate*** must be the agency's internal audited fringe rate, with a maximum of **62.0%.** Verification of this rate is subject to audit. Fringe is defined as government-mandated and employer-selected employee benefits, including social security, unemployment, workers and disability compensation, retirement programs, and health insurance.
8) Non-personnel, expense line-item titles should be specific (e.g., Food, Office Supplies, Staff Training) and listed under the ***Other Direct Care Costs*** column.
9) The ***HHS Indirect Approved Rate*** line item is capped at 10%. Subrecipients who wish to use an indirect rate must provide documentation of a Certificate of Indirect Costs that is **HHS-negotiated**, signed by an individual authorized to sign on behalf of the subrecipient. Any other Federal or State agency that has conducted and issued an audit report of the subrecipient's indirect cost rate that has been developed following the requirements of the cost principles contained in 48 CFR part 31 will also be accepted. Please note, that the 10% de minimis rate may be used if the subrecipient has never had a negotiated rate.
10) The ***Administrative Costs*** column should be specific. These costs include recognized overhead activities, including rent, utilities, and facility costs. It also applies to the costs of management and oversight of the specific program funded. It includes program coordination, clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; and computer hardware/software not directly related to patient care. Administrative Costs are funded at a maximum rate of 10% of the total direct program costs. Subrecipients are responsible for preparing a project budget that meets administrative cost guidelines and provides expense reports that track administrative expenses.
11) ***The Service Award Total*** is the sum of the direct care total and the administrative or indirect rate cost total.

Budget Revision Guidance

When to Submit a Full Budget Revision Request Packet for Approval:

Below is a list of post-award changes to a Part A funded service that require the submission of a full budget revision request packet for prior approval by Ryan White Services staff:

1. When transfers among line items such as Personnel, Fringe, Travel, Equipment, Supplies, Contractual, etc. for the current budget period exceed 25% of the total approved line item for that budget period.
2. When a subrecipient wants to add a new line to a budget.
3. When substantial changes are made to the approved work plan or project scope (e.g., changing the model of care, transferring substantive work from personnel to contractual; (or)

4. When a subrecipient is significantly underspending on a budget line item and would like to propose new means to meet their deliverables and utilize their full funding, this is especially important in the case of staff vacancies.
5. When the subrecipient wants to purchase a piece of equipment that exceeds $5,000 and is not included in the approved award budget, see budget revision instructions at the end of this section.
6. Any changes in personnel salary, FTE, or billing months.

When Budget Revisions Packets are not Required:

Agencies DO NOT need to submit a full budget revision request packet for approval for the following circumstances:

1. The billing of direct cost budget lines (i.e., Personnel, Fringe, Travel, Equipment, Supplies, Contractual, etc.) is over-or-under the original line cost but is within the 25% leeway.
2. Personnel changes for replacing a TBD/TBH line with the name of a new employee at the SAME salary, FTE, and billing months that were initially proposed in the award budget at the beginning of the fiscal year before you start billing.
3. Changing the title or the name of an employee.

Under these circumstances, agencies must submit the invoice indicating changes along with required backup documentation.

All staff updates should be effective on current budgets no later than 30 days post the receipt of invoices.

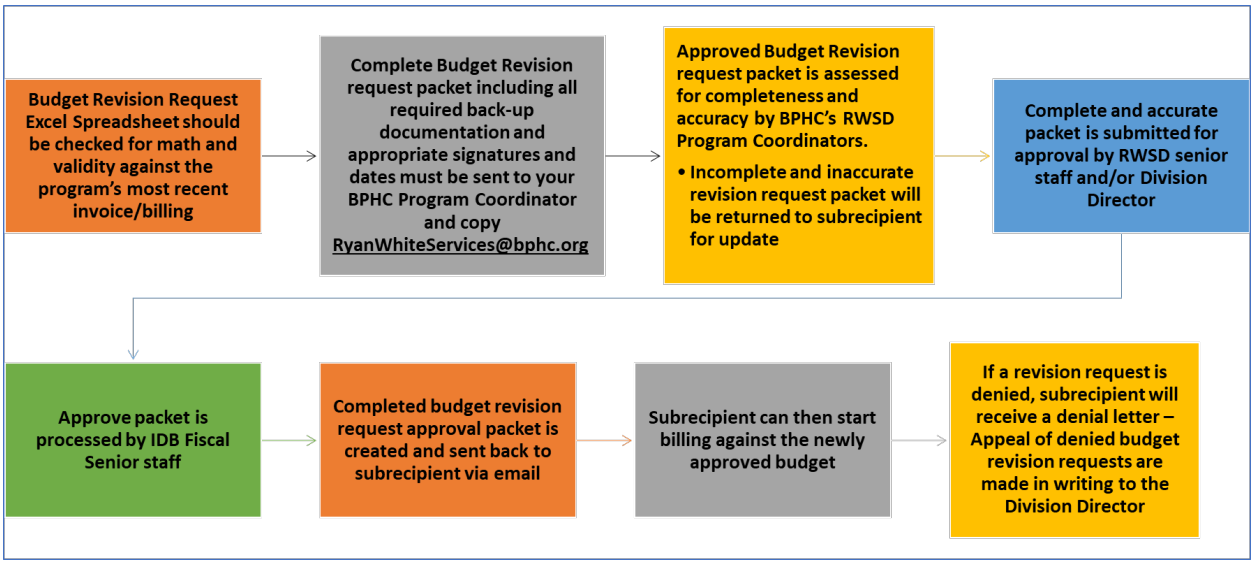
How to Submit a Budget Revision for Prior Approval:

Subrecipients must follow the procedure outlined below to request budget revisions for prior approval. Please see the samples included in the Provider Manual for further clarification. Submit budget revision requests via email to your assigned BPHC Program Coordinator and copy ryanwhiteservices@bphc.org.

1) Each Budget Revision Request Packet must include the following items:
   a. **Budget and Service Delivery Target Revision Request Form**
   b. **Budget Revision Request Excel Spreadsheet**: A current budget with the proposed changes made in the same format as the award budget. The proposed changes should be listed to the right of each person and/or other direct care cost line items in the Excel template. If the budget revision does not match the most up-to-date award budget, it will be returned to the subrecipient.
   c. **Supporting Documents**: including but not limited to staff qualifications (resume), proof of annual salaries such as offer letters or payroll statements, the job description of the duties and responsibilities as they relate to the Part A funding, etc.
      i. For new hires, please provide the following:
         1. A resume showing qualifications.
         2. Proof of annual salary such as an offer letter or payroll statement.
         3. A brief description of the position's duties and responsibilities as they relate to the funding.
      ii. For a consultant, please provide the following:

1. A resume showing qualifications.
2. A detailed description of the services/activities to be performed by the consultant.

2) Once the Ryan White Services (RWS) team reviews a budget revision request according to our internal review protocol, we will notify the subrecipient if there are questions or information that needs to be approved or denied.
3) The RWS team is committed to working with subrecipients to understand and support their changing program and budgetary needs during the budget revision request process. In the case that a budget revision is denied, initial appeals of denied budget revision requests are made in writing to the Interim Bureau Director, Tegan C. Evans at TEvans@bphc.or. Further appeals may be submitted, in writing, to Regis Jean-Marie (rjeanmarie@bphc.org), Infectious Disease Bureau Administrator.
4) Budget revisions will be accepted until December 15, 2025. Revisions submitted after this deadline will only be considered to fill vacant positions and for legal name, position, and title changes.



Budget Revision Request Instructions

Procedures

1) Complete the "Budget Revision Request Form"
2) Complete the Budget Revision Excel Form
3) Include all required supporting documents.
4) Submit the Budget Revision packets with all required documents to your contract manager and copy RyanWhiteServices@bphc.org.
5) Incomplete packets (missing information, inaccurate information, or missing documents) will be sent back to the agency before processing.

Notes

1) Please complete a Budget Revision form separately for each Service Category Budget awarded to the agency.

2) It is recommended that the program and finance staff at the agency coordinate the submission of all budget revisions.
3) The authorized representative is considered any Ryan White Part A designated contact that your contract manager has listed for your agency.
4) Your assigned contract manager or another Ryan White Services staff will reach out to your program or fiscal contacts for additional information regarding your request if needed.

Checklist

☐ Agency and Submission Information:

☐ **Agency**: Name of agency

☐ **Service Category**: Enter the name of the Service Category

☐ **Date of Request**: Enter the date submitted

1) **Change of Position, FTE, Salary, and Titles**

☐ **Line Split**: A line split refers to dividing a single position or expense across multiple months within the fiscal year to reflect changes in new personnel, changes in salaries, and FTE adjustments. This ensures that budgeted funds accurately align with staffing changes that occur throughout the fiscal year.

- When is a Split Line Needed?
    - Salary/Title Changes:
        - If an employee transitions to a new role partway through the fiscal year, the budget must be adjusted (months and title) to reflect different salary rates for each period.
    - FTE Adjustments:
        - If grant-related activities/workload changes partway through the fiscal year, FTE adjustments can be made to reflect actual time and effort on the grant for specific time frame during the budget period. As a reminder, changes in FTE may affect total FTE for a given staff across budgets. Total FTE for any staff across budgets cannot exceed 1.00 FTE.
    - Personnel Changes:
        - When different individuals fill the same position at different periods (months) of the fiscal year, a line split can reflect these transitions.

- Insert the initial date that the line split begins and the end date of the line split.
- If a line is not splitting or the subrecipient is requesting an additional line item, updating a TBD, or a name adjustment, mark **no**.
- You do not need to list each row that is created when a position is split to reflect adjustments within this section.
- You are **required** to indicate that the line is being split.

☐ **Personnel Name**: Enter the legal name of the personnel

☐ **Position**: Enter the official position title

☐ **Start Date**: Enter the date a change in personnel will effectively start

☐ **End Date**: Enter the date a change in personnel will effectively end

☐ **Reason for the adjustment**: Enter the reason/justification for the adjustment or change of line.

☐ **Supporting Documentation**: **REQUIRED** to move forward with revision

☐ Offer Letter: title, start date, salary, location, etc.

☐ Job Description

☐ Resume

☐ Payroll Forms (Payroll Action Form, Change of Salary Form, etc.)

2) **Changes of Other Direct Service or Indirect Service Lines**:

☐ **Line Item/Position**: Enter the Assigned line item or title of personnel

☐ **Personnel Name**: Enter the legal name of the personnel (if applicable)

☐ **Line Split**: A line split refers to dividing a single position or expense across multiple months within the fiscal year to reflect changes in new personnel, changes in salaries, and FTE adjustments. This ensures that budgeted funds accurately align with staffing changes that occur throughout the year.

☐ **Start Date**: Enter the date a change in personnel will effectively start

☐ **End Date**: Enter the date a change in personnel will effectively end

☐ **Current Budget**: Enter the amount budgeted for the line item.

☐ **New Budget**: If any funds have been invoiced to BPHC, list the culminated amount found on the most recently submitted Monthly Invoice, Section D.

- Reminder that administrative costs are capped at 10% unless otherwise approved by BPHC.
- If already billing for this change, please ensure that previous invoices align with the proposed budget revision.

☐ **Reason for Change**: Enter the reason for the adjustment or change of the line.

☐ **Supporting Documentation: <u>REQUIRED</u>** to move forward with revision

☐ Quotes or estimates (i.e. consultants, system fees)

☐ Consultants: justification/service description, timeline, receipts, etc.

☐ Fringe Rate/ Indirect Rate Certificate

☐ Vendor Description

3) **Signatures**:

☐ **Name of Authorized Representative**: The authorized representative must be a person with budgetary decision-making authority.

☐ **Title**: Input the title of the authorized representative.

☐ **Email**: Input the email of the authorized representative.

☐ **Signature**: Input the signature of the authorized representative.

☐ Complete the Budget Revision in Excel Form.

☐ Include all required supporting documents.

☐ Submit the form to RyanWhiteServices@BPHC.org

Fiscal Compliance

Under the Ryan White HIV/AIDS Treatment Modernization Act of 2009, there are significant penalties to the EMA if there are unexpended dollars at the end of the fiscal year. Therefore, all programs must spend 100% of their contracted award. Contract expenses, as shown on invoices, are reviewed each quarter of the fiscal year. The subrecipient is informed after the first quarter, in writing, of any underbilling. Any contract underbilled through the second quarter may be reduced. If the underspending is due to a late start, the reduction to the subrecipient award is equal to the amount of year-to-date spending. If the underspending is an ongoing concern, the reduction of the award will equal year-to-date expenditures and the projected underspending to year-end. RWS will reallocate funds to other subrecipient budgets following the Ryan White Planning Council's service priorities. Reallocations within individual categories and the resulting contract revisions do not require Planning Council approval**.**

BPHC will only pay for expenses properly presented and documented on invoices. The subrecipient may be held in "non-compliance" at the end of each month if the invoicing requirements are not met. Non-compliance includes non-submission of invoices or late invoices. RWS will lift non-compliance once all the submission meets requirements.

Contract spending may vary by up to 25% monthly within a budget line item if the total amount billed does not exceed the budget's maximum obligation for the fiscal year. For example, if you project a charge of $500 to a monthly salary (annual salary of $6,000), you may spend $625 within that line per month (therefore, it cannot exceed $7,500 annually) with sufficient backup. For other direct care costs, e.g., if you are budgeted for a $1,000 office supply line for the year, you may spend up to $1,250 within that line (you may bill this in one month, or it may be divided among several months). Overspending of the contract will not be paid. Any changes over the 25% leeway may require prior approval for re-budgeting from the HIV/AIDS Services Division in the form of a budget revision request. Contract funding for a Part A fiscal year may not be used in a subsequent fiscal year. Fiscal years are discrete; the funding is separate and is not "carried over." This does not prevent the purchasing of supplies during one fiscal year that may be used in the current fiscal year and subsequent fiscal years.

Audits

Subrecipients that expend $1,000,000 or more in Federal awards during a fiscal year must have a **Single Audit** of their financial records conducted in accordance with the 45 CFR Part 75 Subpart F. Subrecipients that expends less than $1,000,000 in Federal awards for the fiscal year are exempt from the Federal audit (**Single Audit**) requirement for that year; however, their complete financial records must be available for review or audit by appropriate officials of the Federal agency (HRSA), pass-through entity (BPHC), and the Government Accountability Office (GAO).

All subrecipients are required to submit their most recent **Single Audit Report** (if applicable) and their **Financial Statement Audit Report with Management Letter** to **AuditReports@bphc.org**, no later than **June 30, 2025**.

If electronic submission is not possible, mail a hard copy of the audit reports to:

Post-Award Grants Director

Boston Public Health Commission
1010 Massachusetts Ave, 6th Floor

Boston, MA 02118

Also, this audit and all required fiscal records must be available at the subrecipient fiscal location for review during the on-site fiscal monitoring review.

Additional Funding Restrictions

1) Part A funds may not be used for payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made, concerning that item or service under
    a. any State compensation program, insurance policy, Federal or State health benefits program or by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services or the U.S. Department of Veterans Affairs; see HAB PCN 16-01 for additional information regarding services provided to veterans at the following source. It is therefore incumbent upon subrecipients of Part A funds to ensure that eligible individuals are expeditiously enrolled in Medicaid and that Part A funds are not used to pay for any Medicaid-covered services for Medicaid-eligible PLWH. Part A subrecipients are subject to audit on this and other restrictions on the use of funds.
2) If a service is available under the state Medicaid Plan, the political subdivision involved must either provide the service directly or agree with a public or private entity to provide the service. The subrecipient providing the service must enter into a participation agreement under the state Medicaid plan and must be qualified to receive payment under the state Medicaid plan.
3) If Part A subrecipient charges for services, it must do so on a sliding fee schedule that is made available to the public. Individual annual aggregate charges to clients receiving Part A services must conform to statutory limitations. The intent is to establish a cap on charges to Part A service recipients.
4) Establishing a fee schedule should not result in a bureaucratic system to means-test individuals or families before Part A supported services are provided. A simple application that requests information on the annual gross salary of the individual/family should provide the baseline by which the caps on fees will be established.

Individual & Family Annual Gross Income and Total Allowable Annual Chargers

Individual/Family Annual Gross Income	Total Allowable Annual
Equal to or below the official poverty line	No charges permitted
101 to 200 percent above the official poverty line	5% or less of gross income
201 to 300 percent above the official poverty line	7% or less of gross income
More than 300 percent above the official poverty line	10% or less of gross income

5) Funds may not be used to purchase or improve land or to purchase, construct, or make a permanent improvement to any building except for minor remodeling.
6) Funds may not be used for international travel. Funds may not be used to make cash payments to intended clients of core medical or support services. This prohibition includes cash incentives and cash intended as payment for RWHAP services.

7) Where the direct provision of the service is not possible or practical, store gift cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. Subrecipients are advised to administer voucher and store gift card programs in a manner that assures that vouchers and gift cards cannot be exchanged for cash cards.
    a. **Note:** General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express. They are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are co-branded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are also unallowable. Furthermore, agencies distributing gift cards require an agency policy that outlines the purpose of gift cards as related to the service provided, how gift cards will be secured, how the agency will determine the allocation and track distribution to clients (for example client, date, amount, purpose, vendor, client signature), and how the agency will communicate what the gift cards can and cannot be used for (including alcohol, cigarettes, firearms, and other items not allowed). Gift cards cannot be an incentive but need to be utilized to support service directly. For example, gift cards to a grocery for food service or Emergency Financial Assistance could be allowable. Still, gift cards cannot be provided for participation in a service such as psychosocial support groups or training, as that is considered an incentive.
8) Use funds in a manner consistent with current and future program policies developed for Part A regarding allowable categories of services and eligibility for services. Please review all current HRSA/HAB and BPHC program policies.
9) Do not use Part A funds for outreach programs that have HIV prevention education as their exclusive purpose or broad-scope awareness activities about HIV services that target the public.
10) Recipients of grant funds must participate in a community-based continuum of care. A continuum of care is defined as:
    a. A comprehensive continuum of care includes primary medical care for the treatment of HIV infection that is consistent with Public Health Service guidelines. Such care must include access to antiretrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections, as well as combination antiretroviral therapies. Comprehensive HIV care also must consist of access to substance abuse treatment, mental health treatment, oral health, and home health or hospice services. Also, this continuum of care should include supportive services that enable individuals to access and remain in primary medical care as well as other health or supportive services that promote health and enhance the quality of life.
11) Consistent with Departmental guidance, subrecipients that purchase, are reimbursed, or provide reimbursement to other entities for outpatient prescription drugs are expected to secure the best prices available for such products and to maximize results for the subrecipient organization and its clients. Eligible healthcare organizations/covered entities that enroll in the 340B Program must comply with all 340B Program requirements and will be subject to audit regarding 340B Program compliance. 340B Program requirements, including eligibility, can be found at www.hrsa.gov/opa.
12) Funds awarded for pharmaceuticals must only be spent to assist clients who have been determined not eligible for other pharmaceutical programs, especially the AIDS Drug Assistance Program, and/or for drugs that are not on the State ADAP or Medicaid formulary.
13) Subrecipients are required to track and report all sources of service reimbursement as program

income in annual data reports. All program income earned must be used to further the objectives of the RWHAP program. For additional information, see PCN #15-03 available online and below in the Policy Clarification Notice section.

14) The actual amount of funds expended on administrative costs by subrecipients shall not exceed 10% of the **Aggregate Total of All HIV Service Dollars Expended**. For the 10% aggregate cost cap, administrative activities include:
    a. Usual and recognized overhead activities, including rent, utilities, and facility costs.
    b. Costs of management oversight of specific programs funded under this title, including program coordination, clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; and computer hardware/software not directly related to patient care.

Clinical Quality Management Requirements & Opportunities

HRSA **Policy Clarification Notice 15-02** requires recipients to establish a Clinical Quality Management (CQM) program to support improving client care, health outcomes, and client satisfaction. BPHC's Ryan White CQM Program aims to enhance the EMA's capacity to integrate quality improvement into the work by providing training, technical assistance, and access to other resources that address the three main components of a Ryan White CQM program: Infrastructure, Performance Measurement, and Quality Improvement (QI).

Infrastructure

1) **Ryan White Quality of Care Committee:** An advisory committee representative of the demographics of the EMA that guides, advises, and provides input on all aspects of the Ryan White Clinical Quality Management Program. To express interest in joining the Quality of Care Committee or to apply, complete this form.
2) **CQM Plan:** The BPHC CQM Plan details a three-year strategy to improve the quality of Ryan White services. This plan highlights the quality improvement goals of the Boston EMA and includes a plan to measure program performance. The CQM program will continue to support the overall EMA goals to build a quality improvement culture among subrecipients and to increase viral suppression among PLWHA. You can find an up-to-date version of the FY 25 – 27 CQM Plan in the E2Boston Resource Center, or on our website.
3) **IHI Open School:** The CQM Program maintains an IHI Open School group subscription with licenses for Ryan White Part A stakeholders who are looking to enhance their skill set in conducting improvement work. Providers are **expected to complete four (4) annual coursework credits** on Quality Improvement through the Institute of Healthcare Improvement (IHI) Open School learning platform. Please complete registration here.
    a) This subscription is free of charge to Ryan White Part A stakeholders and lasts for up to one year, with the option to renew. Please contact the CQM team at cqm@bphc.org if you would like to discuss your QI learning goals and coursework in Open School that can help you achieve them.
4) **E2Boston:** E2Boston is a cloud-based database that houses client-level information for Part A and the Ending the HIV Epidemic grants. Every funded provider under these two grants is

required to enter clients' eligibility, demographic, medical, services, and health outcome information into E2Boston. The CQM program relies heavily on the aggregate reports that are generated in E2Boston to understand program performance in the Boston EMA. These reports help the CQM team and Quality of Care Committee to identify areas of improvement, quality gaps, and improvement success.

Performance Measurement

1) **Quarterly Data Displays:** A data display is a visual tool that displays each agency's performance measurement data (i.e., viral suppression rates, ART adherence) based on E2Boston data. Each quarter, CQM staff will create and share data displays for a subset of services across the EMA, currently including Medical Case Management, Non-Medical Case Management, Oral Health, and Food Bank/Home Delivered Meals. These displays are intended to review data from the service categories that serve 15% -50% or more clients in the EMA. This visual tool displays aggregate client outcomes over time and can be used as a basis for developing data-driven quality improvement initiatives to improve client outcomes.
2) **E2Boston Reports:** The CQM Team uses HAB Measures, Outcome Measures Distribution, and Demographics reports to evaluate program quality and identify improvement opportunities. CQM staff also use the Performance Summary report, Outcomes Submission Status report, and System Alerts to help monitor data quality.
3) **System Alerts:** Subrecipients are encouraged to run the Outcomes Submission Status report and/or check System Alerts at least once per month to help ensure timely and accurate entry of Outcomes data. Please note that E2Boston users can subscribe to weekly email summaries of system alerts.
4) **Quality Improvement (QI) Culture Assessment:** The purpose of this assessment is to evaluate the current quality improvement activities and capacity of subrecipients and to identify strengths as well as opportunities to improve. The assessment informs the CQM team of subrecipients' QI goals and projects and serves as a benchmark for improvement projects. **This assessment is required to be submitted by applicable subrecipient staff annually.**

Quality Improvement

1) **Service Category Quality Improvement (QI) Project:** Each year, the CQM team will conduct a collaborative quality improvement project in a service category selected by the QOC committee. This project will aim to collaborate with agencies to improve a key measure of their service delivery model towards client health outcomes and/or retention/engagement for the selected service category. Participation is required from the subrecipients funded for whichever category is selected.
2) **Subrecipient Quality Improvement (QI) Projects**: Part A subrecipients are encouraged to conduct QI projects each fiscal year. The CQM Program can support those projects that aim to improve consumer care, health outcomes, and consumer satisfaction among Part A clients

within the Boston EMA. CQM staff can provide technical assistance, QI training, tools, and other resources., and financial assistance through mini-grant funding for projects that align with system-wide priorities.

3) **Quality Improvement (QI) Learning:** The CQM Program aims to provide learning opportunities related to high-priority improvement areas (as determined by the QOC Committee) and provide a library of QI resources and training modules for Ryan White stakeholders within the Boston EMA.
4) **Consumer Capacity:** The CQM Program is committed to training consumers to build their capacity in Quality Improvement methodology.

Expectations of Subrecipients

1) Participate in monthly call discussions about CQM. We encourage agencies to consider which funded staff should be part of quality work and conversations.
2) Complete the annual QI Culture Assessment.
3) Complete credit requirements in IHI Open School.
4) Enter clients' health outcomes data into E2Boston once every six months.
    a. All E2Boston users should complete E2Boston training videos/slides, which can be found in the **E2Boston Resource Center**.
    b. Use E2Boston reports to better understand the quality and performance of your Ryan White service(s).
5) We strongly encourage agencies to engage with the CQM Program in at least two ways each year, for example:
    - Participate in our QI Collaborative.
    - Schedule **CQM Office Hours** to discuss your agency's QI work and/or receive QI coaching.
    - Complete a QI project in your Ryan White program.
    - Fulfill QI training requirements by completing courses on QI in **IHI Open School**.
    - Join the **Ryan White Quality of Care Committee**.
    - Attend a training hosted by the CQM team.

Clinical Quality Management Resources

1) **Monthly Monitoring Calls:** CQM-related questions are incorporated into the monthly call agenda that is facilitated by each agency's Contract Manager. These questions serve as a check-in on the quality improvement work and opportunities in each Part A program and create a space for open discussion about performance measures. This component of the monthly monitoring calls is meant to promote a culture of continuous Quality Improvement and ensure that agencies are efficiently connected with CQM staff for any needed TA.
2) **CQM Office Hours:** CQM staff now offer office hours to all Part A subrecipients for technical assistance and other CQM-related questions! Click here to schedule CQM Office Hours.

3) **E2Boston Training:** Please refer to the E2Boston Resource Center for training content pertaining to data entry and reports, including entry of Outcomes data and utilization of CQM reports.
4) **Supplementary CQM resources:** In the E2Boston Resource Center under the section labeled "CQM Information." These additional resources provide subrecipients with up-to-date Ryan White CQM initiatives and relevant explanatory material. Subrecipients are encouraged to utilize these materials and the CQM Office Hours to ensure their QI initiatives are implemented with evidence-based practices and methodology.

E2Boston

E2Boston is the BPHC Data Collection system, powered by eCompas, that was created to collect, track, and analyze the clients' and services information in Boston EMA.

This section includes general information about how to complete the client's information, add services and subservices, report client outcomes, and complete the Ryan White Services Report using the E2Boston database. If you require more assistance, please review the E2Boston User Manual found within the Resource section of E2Boston or contact Irina Neshcheretnaya at ineshcheretnaya@bphc.org.

Please note that E2Boston trainings (slides and videos are available in the E2Boston Resource Center) is ***mandatory*** to view for all **new** case managers. **It is the responsibility of the agency** to ensure that case managers watch and inform the Ryan White Program to get certification.

E2Boston Trainings

The Ryan White Services published several training courses to supplement and support the Boston EMA agencies' knowledge and skills regarding E2Boston. It is **the responsibility of the agencies to conduct training for their employees** in the use and application of the system. The training released by the team is intended to provide an introduction and be an additional resource for the agencies and data enterers.

The available trainings can be found in the E2Boston Resource Center under the section labeled, "E2Boston User Trainings Slides" and "E2Boston User Trainings Videos". E2Boston training content is offered in both PowerPoint slide and video format to ensure accessibility of E2Boston trainings. When E2Boston users click on the highlighted text in either section, they will either download the slides or open a new tab with the linked video.

Each video provides background information about the topic of the training, pertinent information on its application, and step-by-step tutorials by the RWS Data Manager on how to perform specific activities.

Please review the E2Boston announcements and Ryan White Services newsletter for more information about additional/updated training courses and system changes coming out for Fiscal Year 2025.

Services & Subservices

Reporting Units into E2Boston and Unit-Rate documentation

Programs are required to use E2Boston to track service utilization for funded activities. BPHC uses the client code and unique client identifier to link service activities to specific clients. **All programs must enter, upload/import utilization data into E2Boston monthly.** *Monthly data entry is due each month by the 30th of the following month. For example, April data needs to be entered by May 30th.

Types of Reporting Units

While the reporting deadlines and requirements vary for expense reimbursement and unit-rate programs, client activity itself is reported similarly for both types of programs. RWS will use client utilization data as support documentation for units billed. Client activity is recorded in two ways:

1) **Time-Based Units of Service**: If a subservice is an hourly time-based activity, use quarterly increments to reflect the time-based activity. *Examples:*
    a. If a client meets face-to-face with his Case Manager for 15 minutes, record the visit as 0.25 units.
    b. If the staff holds an individual psychosocial support session with a client for 75 minutes in her office, record the visit in 1.25 units.

2) **Units of Service:** When recording discrete service activities tied to a unit-rate budget or line item (e.g., foodbank packages, bed days, supported referral), record the unit as one (1). *Examples:*
    a. A completed Case Management Intake should be recorded as one (1) unit.
    b. A completed supported referral should be recorded as one (1) unit.
    c. A transitional housing program funded to provide bed days for clients would record each bed day provided for each client as one (1) unit.
    d. A meals program funded to provide food bank packages for clients would record each package distributed to clients as one (1) unit.

Important Notes:

- **E2Boston does not allow users to enter a service for Inactive clients.**
- **The system saves the service entry for Ineligible clients, but this client and these services will not be included in the RSR report.**

Client Information: Intake, Demographic, HIV Status, and H&I Statis tabs

This entire E2Boston part collects the client's information and verifies the client's eligibility. It consists of several pages/tabs, each of which requires completing and saving the information. The system highlights the required data elements for a client's record. **All pages/tabs in the client record,** including demographics, **use red asterisks (*) to indicate mandatory fields.** However, we encourage you to fill in as much information as possible, such as the Client's Primary Language and Country of Birth.

Intake Information/Add a New Client

When you create a new client record, first you have to enter data into the Client Intake page. This is

mandatory because E2Boston uses this information to create a **Unique Client Identifier *(UCI)** and **a Client Code**.** In addition to that the system verifies if the client already exists and tries to prevent duplication of the same record.

* Unique Client Identifier *(UCI)- Automatically created code to identify/track clients. Contains:

- 1st and 3rd letters of **First Name**,
- 1st and 3rd letters of **Last Name**,
- **Date of Birth, and**
- **Gender Identity Option** code**.**

** Client Code- Automatically created code to identify/track clients. Contains:

- First 3 letters of **Mother's First Name**,
- **Date of Birth**, and
- **Last 4 Digits of Social Security Number (SSN)**

Demographics Tab

On any given page, you must fill in all the asterisked fields before you can save the information. E2Boston requires most of this demographic data for the Ryan White Services Report (RSR), which must be submitted to HRSA annually. Complete all possible data entry fields now, to prevent missing the data and/or spending your time coming back and filling in the same page again.

The Demographics tab has two sections: Residency and Client Demographic.

- *The residency section collects information about the client's address, including zip code and state, and checks if the client meets the residency eligibility criteria. This is one of the main components of Ryan White eligibility
- Client Demographics holds the client's contact details, client's Vital and Activity statuses, Race, Ethnicity, and other information.

HIV Status Tab

This page contains information about the client's HIV status, Medical Visits, and Linkage to Care information as well as the original exposure category.

1) E2Boston allows reporting multiple exposure categories per client.
2) The HIV status should be updated if the client's status changes (i.e., Diagnosed with AIDS).
    a. *The Diagnosis Year **is mandatory** information, and the diagnostic day and month are required if the client has been diagnosed after 2020.
3) Medical Visit Date is requested and collected once upon intake which shows the date of the first medical visit after the client has been diagnosed.
4) Linkage to Care is the section where the information about the client's current HIV/AIDS Medical Provider and the most recent HIV Care Date/medical visit should be provided.

H&I Status Tab

This tab of the client record contains Income, Medical Insurance, and Housing information.

- The first two are other **main components** of Ryan White eligibility.

***Please note:** When reassessing a client for eligibility, this section must be updated **each** time.

E2Boston: Data Sharing and Eligibility

E2Boston is a data-sharing system that allows Boston EMA providers to input new client information, client data, provider services, subservices, client outcomes, and complete annual Ryan White Services reporting requirements. The system includes a data sharing and eligibility module as an additional E2Boston provider feature. The goal of the data sharing and eligibility module is to centralize access and control of client eligibility data, with client consent, allow Boston EMA providers to assess client eligibility for Ryan White Part A services across multiple providers based on client eligibility information already inputted in the E2Boston system by other Part A providers.

The data sharing and eligibility module benefits Boston EMA providers in the following ways:

- ✓ Reduce administrative burden for Boston EMA providers and clients
- ✓ Significantly improve the quality and accuracy of RWS client data
- ✓ Reduce the risk of client duplication
- ✓ Reduce the burden of duplicative data entry
- ✓ Improve collaboration between RWS-funded agencies

*__Important Note:__ HRSA's Ryan White Part A eligibility requirements have not changed since FY21. A summary of eligibility verification/documentation requirements is in Appendix 2 and further guidance is in the Service Standards and Provider Manual. Please contact your contract manager with questions.

Data Sharing

The ONLY client information that is shared as part of the Data Sharing and Eligibility module is the following:

- Client's intake data, including all Client Code and UCI components
- Client's Eligibility Status and dates, including uploaded forms and verification documents
- Client's demographic data
- Contact information and residency information
- Income, Housing, and Insurance information
- Record(s) of HIV/AIDS diagnosis and/or status
- Medical Care Visits and Linkage to Care
- **New for FY 25:** Medical and Quality of Life Outcomes information.

***Important Note:** No other information such as received services, subservices, and/or service dates will be shared when using the Data Sharing and Eligibility module.

Ryan White Dental Program and Shared Eligibility

When referring clients to the Ryan White Dental Program (RWDP), please note that the RWDP **requires** submission of specific sections of the RWDP application. These include:

1) Section 1: Client's Name and Date of Birth (DOB) (RWDP Enrollment Form)
2) Section 2: Mailing Address (RWDP Enrollment Form)
3) Section 3 (RWDP Enrollment Form)

4) Section 5 (RWDP Enrollment Form)
5) Full Completion of the Consent for Release of Information of the RWDP application
6) Full Completion of the Grievance Procedure of the RWDP application

At a minimum, the above-mentioned sections are mandatory to receive services with the RWDP. Other portions of the application including verification of income, residency, health insurance, HIV status, and client demographic information can be obtained from shared eligibility. However, the other items mentioned above (Section 1 (client's name, client's DOB), Section 2 (mailing address) Section 3, and Section 5, Consent page, Grievance page of the RWDP application) cannot be and are needed for completion of the referral. **In efforts to reduce lags or gaps in care, agencies should work to ensure that annual certification and dental documents dates align.**

Re-certification applications sent **earlier than 30 days** before the previous expiration date **will not be processed**, case management or the client will be notified, and the application will be destroyed.

If you have any questions or to verify eligibility, please do not hesitate to contact the RWDP. If you require a translated dental application, please visit the Ryan White Dental Program website.

Provider Expectations

Agencies are expected to follow the guidance below when using the Data Sharing and Eligibility module.

When Making a Referral to Another Part A Agency

When agencies refer a client to another Part A agency in the Boston EMA, they must:

1) Ensure eligibility status is current, and that eligibility documentation is uploaded into E2Boston;
2) Complete and upload the **Consent and Authorization to Share Information Form **** developed for the Data Sharing and Eligibility Module. Please note that if the client declines to authorize sharing, the information cannot be shared, and each agency will have to verify eligibility through a separate process.

   ***Important Note:** The purpose of this **Consent and Authorization to Share Information Form** is to allow the sharing of individual data when seeking services at two or more agencies, or to revoke the sharing of data if the client no longer wishes to share eligibility data with those agencies. This consent will remain valid for one year or until revoked by the client. If the client wishes to revoke their consent form, they must do so in writing and must resubmit the consent form indicating their revocation to an agency within the system.

   **** A copy of the Consent and Authorization to Share Information Form** also may be downloaded from **E2Boston Resource Center**.

Identified Information

Identifiable information that may be shared between agencies based on consent, includes the client's demographic data, names, codes components, contact information,

financial/employment/socioeconomic data, insurance information, assigned client identification code, and record(s) of HIV/AIDS diagnosis and/or status, client's outcomes information.

De-identified Information

In order to monitor agency contracts, the above identifiable information may also be de-identified to become accessible to the RWS as the Ryan White Part A Recipient, their program and administrative staff or consultants, and RDE Systems, the organization providing the software and technical support for the E2Boston system.

Revoking Consent

As part of the Data Sharing and Eligibility Module, Ryan White Part A clients will be able to revoke the authorization to share information with the agencies identified for which they were previously allowed to use and disclose identifying information to determine their eligibility to receive services.

E2Boston Eligibility Tracking and Upload Requirements

1) **Eligibility Tracking and Uploading for Already Existing Clients**
    a. Agencies must enter eligibility status and upload all required eligibility documentation for existing active clients the next time eligibility status is checked or within one year of client activity/services *(sooner if referring clients to another Part A funded agency-see #1)*. Sample Annual Recertification Summary form and list of accepted verification documentation can be found within the Policies and Procedures section of the Provider Manual or in the E2Boston Resource Center. This template is available for your agency to use or base your internal forms on.
2) **Eligibility Tracking and Uploading for New Clients**
    a. The RWS expects providers to enter the eligibility status information and upload the required documents for all new clients into E2Boston. The E2Boston upload engine processes several formats and the documents can be scanned and/or photographed and posted into the system. Accepted document formats include pdf, doc, docx, jpg, jpeg, tif, tiff, and png.

***Important Note:** RWS understands that sometimes providers may need to provide services before all eligibility documentation has been collected. If this is the case, and a provider serves a client before all eligibility documentation is collected, providers must enter eligibility status and documentation into E2Boston as soon as it is collected. E2Boston will still allow client information and data to be entered even if eligibility status/documentation is not yet complete.

3) **Extension of Deadlines for Documentation Uploads**
    a. For agencies that are doing automatic data uploading/data importing into E2Boston, the process will continue to be the same. The main change is the new MS Access RSR Plus template in the Conversion tab. This template has a new table where agencies can enter

both the eligibility document type and the signature/effective date. The special table for clients' residency information can be found there as well.

b. E2Boston does not have the capacity to import scanned documents, agencies that provide data through the data import module should complete the information about documentation type and signature/effective dates. This information will be enough for the system to change clients' eligibility if that is the case. If a client whose information has been uploaded through the data import module needs to be referred to another agency, the form uploads are required and need to be done manually.

Security Features

Following stakeholder feedback, RWS will continue to keep client data for each agency data separately. Each agency will have access to its own clients only. Information for clients who have been referred to another agency will only be available to subrecipient agencies who have been selected on the Consent and Authorization to Share Information Form. No other agencies will have access to this information. As mentioned above, only some data for referred clients will be shared. This includes all eligibility components, some demographic, and outcomes information. No services and subservices details will be included.

System Alerts

System Alert is a tool to help keep the client's records up-to-date and verify the quality of the data. There are two levels of System Alerts: General System Alert and Client System Alert.

1) **General System Alert** can be accessed from the Main page by clicking System Alert tab near Provider tab. This tab displays the general information about recently referred clients, deadline alerts, needs to follow up, etc.
    a. Each number in these alerts is clickable and the drill-down feature of the system extends it to the list of clients hidden under the number and provides an ability to link to the client's record directly.

There is a Subscribe button on the bottom of the System Alert tab (page needs to be scrolled down). By clicking this button, you will be able to receive the weekly system alert email that displays current system alerts. It also will be possible to unsubscribe from the weekly email on the same place.

2) **Client System Alert** is applied to the individual client's record only and can be seen in the System Alert tab when the client's information is open (just after the Outcomes tab). This tab has a little indicator that shows the number of alerts applied for the client as well as the list of information and potential next steps.

Both System Alerts could be exportable in Excel and PDF formats.

Outcomes Reporting

RWS uses the Outcomes Measure Distribution Report to quantify and track the health of each client served. It is a tool to evaluate the impact of services on key indicators of health and wellness among

clients.

Outcomes Descriptions and Definitions

Subrecipients should use their professional assessment skills when completing the outcomes reporting forms. **Clinical information (i.e., viral load, CD4 count) cannot be self-reported by the client and instead should be collected directly from the client's medical record or reported by the client's medical provider/Medical Case Manager.**

Medical Outcomes:

Clinical information (i.e. viral load, CD-4 count) cannot be self-reported by the client. Instead, this information should be collected directly from the client's medical record or reported by the client's medical provider or Medical Case Manager.

- CD-4 Count: Enter the date and result of the client's most recent CD-4 count test, as shown in the client's medical record or shared by the client's medical provider or Medical Case Manager.
- Viral Load: Enter the date and result of the client's most recent Viral Load test, as shown in the client's medical record or shared by the client's medical provider or Medical Case Manager.
- HAART Prescription: Indicate whether or not the client has been prescribed HAART during the past 12 months. If the client's existing HAART prescription was renewed in the past 12 months, select "yes." If yes, enter the date of the client's most recent HAART prescription or prescription renewal.
- PCP Prophylaxis: Indicate whether or not the client has been prescribed PCP prophylaxis in the past 12 months. If yes, enter the date of the client's most recent PCP prophylaxis prescription.
- Substance Use Screening: Indicate whether or not the client has been screened for substance use in the past 12 months. If yes, enter the date of the client's most recent substance use screening.
- Depression Screening: Indicate whether or not the client has been screened for depression in the past 12 months. If yes, enter the date of the client's most recent depression screening.

Quality of Life Outcomes

Whenever possible, complete the Quality of Life Outcomes based on the direct report of the client, as these questions are intended to measure the client's assessment of their own quality of life. Response options are on a 5-point scale, where "1" represents the most severe impact on the client's quality of life, and "5" represents the mildest impact on the client's quality of life.

- Adherence to Prescribed HIV-Related Medications: Indicate whether the client has been prescribed any HIV medications.
    - If yes, indicate how often the client reports missing a dose of their prescription HIV medications.
- Severity and Impact of Side Effects from HIV-Related Medications: Indicate whether the client reports experiencing side effects from their HIV medications. If the client is not prescribed any HIV medications, select "no."

    - If yes, indicate the severity of side effects reported by the client, as well as how much the side effects they experience affect their quality of life.
- Care Adherence: Indicate how often the client reports missing or needing to reschedule their HIV-related appointments. "HIV-related appointments" includes medical appointments, case management appointments, and appointments for HIV-related medical and support services.
- Mental Health Status: Indicate how the client rates their mental health over the past 6 months, and whether the client is receiving mental or behavioral health services.
- Access to Support Network: Indicate how often the client reports being able to get support when they need it. "Support" can include emotional, social, material, and/or spiritual support.
- HIV Stigma: Indicate how much the client feels HIV stigma affects their quality of life.
- Housing Affordability: Indicate the affordability of the client's current housing situation.
    - If the client reports that their current housing situation is "not at all" or only "somewhat" affordable, indicate whether the client is receiving rental assistance. "Rental assistance" includes both short-term programs such as HomeBASE, RAFT, or RAP, and long-term programs such as Section 8, MRVP, HOPWA vouchers, or ShelterPlusCare.
- Housing Safety and Stability: Indicate the safety and stability of the client's current housing situation.
    - If the client reports that their current housing situation is "not at all," "somewhat," or "moderately" safe and stable, indicate whether the client is receiving housing services.
- Food Access and Affordability: Indicate how often the client can access and afford sufficient food.
    - If the client reports that they can access and afford sufficient food "almost never," "some of the time (25%)" or "about half of the time," indicate whether the client is receiving food assistance.
- Satisfaction with Ryan White Services: Indicate how satisfied the client is with the services available to them from Ryan White agencies.
    - Indicate whether the client is aware of the Ryan White services available to them at the agency where they are currently receiving services and complete this Outcomes form.
    - In 35 words or less, record what the client would like to change or improve about the Ryan White services available to them. **Do NOT enter any Protected Health Information (PHI) into this text box.**

FY 25 Updates to Outcomes Data Collection and Reporting

Starting in FY2025, outcomes data collection in E2Boston will be split into Medical Outcomes and Quality of Life (QOL) Outcomes. For detailed information on the new data entry processes and updated reporting functions in E2Boston, please reference the E2Boston Handbook.

Medical Outcomes

Medical outcomes data **must be collected by Medical Case Management and Non-Medical Case Management** providers, approximately every six months. Collection of medical outcomes data will be aligned with the assessment/reassessment cycle to simplify tracking of outcomes due dates. The Medical Outcomes screen in E2Boston will replace the Medical I tab, the "Labs" and "Care Engagement" sections of the Outcomes tab, and some indicators previously collected in the Medical II tab.

When any one of the following subservices is recorded in E2Boston, the Medical Outcomes form will become available:

- Medical Case Management: Initial Intake, Started
- Medical Case Management: Reassessment, Follow-up/Service Plan, Completed
- Non-Medical Case Management: Initial Intake, Started
- Non-Medical Case Management: Reassessment, Follow-up/Service Plan, Completed

We recommend that providers collect Medical Outcomes data from their clients during the assessment/reassessment visit, to limit how frequently clients are asked to provide information. Once the assessment/reassessment subservice is entered in E2Boston, the Medical Outcomes form will become available for data entry, and it will remain open for data entry for up to **60 days,** counted from the date the subservice was **conducted**. The Medical Outcomes form will be available for data entry to providers from the agency who entered the assessment/reassessment subservice, and **only for up to 60 days**. If the reassessment is entered more than 60 days after it was conducted, the Medical Outcomes form will not open for data entry, and the outcome will be marked as "missed."

When data has been entered into the Medical Outcomes form, the provider will have the option to:
1) Save the form as a draft, with the intention to edit, fill more completely, or submit later, or
2) Submit the form immediately (if all mandatory fields have been completed).

Please note: Once the Medical Outcomes form has been submitted, it **can no longer be edited**.

Medical Outcomes forms that are still in "draft" status 60 days after the reassessment date will be automatically submitted if all mandatory fields are complete. Draft Medical Outcomes forms where one or more of the mandatory fields have not been filled in **will not be saved**. If no Medical Outcomes form has been submitted by the end of the 60 days (including drafts missing data from one or more mandatory fields), the system will mark the Medical Outcomes as **missed**.

The Medical Outcomes form will collect the following data:

- Lab test information, including viral load & CD4 count results & dates (note: this data cannot be self-reported)
- Prescription of HAART & PCP prophylaxis dates
- Substance use & Depression screening dates
- STI & cervical cancer screening dates (optional)
- One-time screening (Hepatitis, TB) dates (optional)

NEW for FY 25: Submitted Medical Outcomes forms will be visible to other providers with data sharing permissions.

Quality of Life Outcomes

Quality of Life (QoL) outcomes data **must be collected annually by all providers**. Collection of QoL outcomes data will be aligned with annual recertification of eligibility to simplify tracking of outcomes due dates. The Quality of Life Outcomes screen in E2Boston will replace the "Health and Quality of Life Measures" section of the previous Outcomes tab, with new and updated questions to improve the breadth and quality of QoL data.

When a client's Annual Recertification form is entered in the Document Tracker, the Quality of Life Outcomes form will become available.

We recommend that providers collect QoL Outcomes data from their clients during the annual eligibility re/certification process, to limit how frequently clients are asked to provide information. Once the Annual Recertification of eligibility is entered in the E2Boston Document Tracker, the form will become available for data entry, and it will remain open for data entry for **60 days**, counted from the date the recertification was **entered**.

When data has been entered into the QoL Outcomes form, the provider will have the option to:
1) Save the form as a draft, with the intention to edit, fill it more completely, or submit later, or
2) Submit the form immediately (if all mandatory fields have been completed).

Quality of Life Outcomes forms that are still in "draft" status at the end of the 60 days will be automatically submitted if all mandatory fields are complete. Draft QOL Outcomes forms where one or more of the mandatory fields has not been filled in will not be saved. If no Outcomes form has been submitted by the **end of the 60 days** (including drafts missing data from one or more mandatory fields), the system will mark the Quality of Life Outcomes **as missed.**

Quality of Life Outcomes forms will be editable during the 11 months after the form was initially submitted. After that point, a client's QOL outcomes information can be updated by submitting a new QOL outcomes form at their next annual eligibility recertification.

The Quality of Life Outcomes form will collect information on the following topics:

- HIV Medication & Care Adherence
- Mental Health Status, Support Network, and HIV Stigma
- Housing & Food Security
- Satisfaction with Ryan White Services (optional)

Please note that the existing outcomes questions have been revised, additional questions have been added, and the response options are now on a 5-point Likert scale. The new QOL outcomes questions are designed to capture the client's assessment of their own quality of life, so collecting this data in direct consultation with the client is recommended.

NEW for FY 25: Submitted Quality of Life Outcomes forms will be visible to other providers with data sharing permissions.

Ryan White Services Report

All Ryan White-funded subrecipients are required to complete the 2025 RSR, which covers the reporting period from January 1, 2025, to December 31, 2025. For FY 2025, subrecipients must use E2Boston to generate the appropriate XML file for their client-level data. E2Boston data entry should only contain information related to Part A clients. Subrecipients receiving funds for multiple Ryan White Programs or other funding sources must use different data systems to track non-Part A clients.

There are three (3) components to the RSR:

- **Recipient Report**: Must be completed by entities funded **directly** by HRSA, including BPHC as the Part A Recipient, DPH as the Part B Recipient, and all directly funded Part C and D providers.
- **Service Provider Report**: Must be completed by **all** Ryan White-funded subrecipients. This report contains information about your agency and the services you provide under Ryan White.
- **Client Report**: Must be completed by **all** Ryan White-funded subrecipients. This report contains the Client Level Data (CLD) and is submitted electronically in an XML format with encrypted client identifiers.

For more information on the RSR, including instructions for completing the RSR and full Client Level Data compliance, it is available at the following website TargetHIV RSR **.**

Support and Technical Assistance

For any questions or technical assistance, please contact (please cc your contract manager in every email):

- CQM Program team, cqm@bphc.org
- E2Boston support group, support@E2Boston.net

For Electronic Handbook help, please reach out to:

- EHB Data support, RyanWhiteDataSupport@wrma.com

Service Descriptions & Subservice Definitions

This section offers the user a description of each Boston EMA service category and the respective subservices. The service description or 'HRSA Description' is intended to outline allowable services within the service category. Some of the service descriptions include program guidance. The purpose of the 'program guidance' is to help recipients and subrecipients implement the services following the Ryan White legislation. The goal and objective for each service category succinctly outline the overall purpose of the service. Subrecipient staff should use these sections to help assess allowable service delivery activity and reporting into e2Boston. Please refer to the Boston EMA's **FY 25 Service Standards** for more detail.

Core Medical Services

AIDS Drug Assistance Program

HRSA Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to income-eligible clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA -approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV. HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost-sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost-effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:

- HRSA RWHAP Parts A, C, and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and health care coverage and medication cost-sharing for ADAP-eligible clients.
- See **PCN 07-03**: The Use of Ryan White HIV Program, Part B AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services
- See **PCN 18-01**: Clarifications Regarding the use of Ryan White HIV Program Funds for Health Care Coverage Premium and Cost-Sharing Assistance
- See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

Goal: Ensure that all people living with HIV have access to and are able to adhere to HIV and other prescribed medical regimens.

Objective*:* Ease the financial burden of medical costs for people living with HIV by providing financial assistance for prescription medication.

Subservice	Definition

Prescription	ADAP reimburses prescription medication claims. The claim must include the drug name, quantity, and the amount paid by Part A. One Unit = One Claim

Medical Case Management

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

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

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every six months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

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

Program Guidance:

- Activities provided under the Medical Case Management service category have as their objective improving health care outcomes. In contrast, those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.
- Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category. In contrast, Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Goal: Engage clients who face significant challenges to enter and maintain treatment for their HIV.

Objectives: Improve health care outcomes for people living with HIV.

Subservice	Definition

Initial Intake, Started	Enter one (1) when the initial intake begins.
Assessment, Completed	Enter one (1) when the assessment is complete.
Visit, General	A face-to-face medical case management session between provider and client. One Unit = One Hour.
Visit, Home-Based	A face-to-face session between provider and client where case management services are provided in a non-office-based setting, including but not limited to residential settings. One Unit = One Hour.
Reassessment/Follow-up Service Plan, Completed	Enter one (1) when the reassessment/follow-up service plan is complete.
Supported Referral	Enter (1) for each active process of connecting a client to any necessary HIV-related or supportive service (i.e., calling and making an appointment with a client, making an appointment on a client's behalf, etc.).
Client Communication	Enter one (1) for each correspondence, communication, or interaction that provides client-centered assistance, either directly with the client or indirectly on behalf of the client, excluding face-to-face sessions with the client. This includes phone calls, voicemail, text messages, and e-mail. Face-to-face sessions should be captured as either general or home-based visits. One Unit = One Correspondence/Communication/Interaction.

Medical Nutrition Therapy

HRSA Description:
Medical Nutrition Therapy includes:

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

These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:

- All activities performed under this service category must be under a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.
- See also Foodbank/Home Delivered Meals

Goal: Optimize immunity, reduce weight loss and nutritional deficiencies, and improve the overall wellbeing of people living with HIV.

Objective: Identify and treat nutritional deficiencies in people living with HIV through the provision of medical nutrition therapy, which includes nutritional counseling and the prescription of dietary regimens by a physician or licensed nutritionist, or registered dietician.

Subservice	Definition
Home Delivered Food	Enter the number of meals or food items delivered to the house of a client or family that requires the service.
Meal, Congregate	Enter the number of meals provided to a client in a group setting that is not the client's home.
Assessment, Nutritional	Enter one (1) when the nutritional assessment is completed.
Visit, General Nutritional Counseling	Enter one (1) for each face-to-face general nutritional counseling session between counselor and client. (does not include initial assessment) One Unit = One Hour.
Food Bank Package	Enter one (1) per can or food package provided to the client.
Nutritional Supplement	Enter one (1) per can or similar supplement package provided to the client.

Oral Health Care

HRSA Description:
Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Goal: Prevent and control oral and craniofacial diseases, conditions, and injuries, and improve access to preventive services and dental care for eligible people living with HIV.

Objective: Increase awareness of the importance of oral health to overall health and well-being, increase the acceptance and adoption of effective preventive interventions, and reduce disparities in access to effective preventive and dental treatment services. (Healthy People 2020).

Subservice	Definition
Initial Intake, Started	Enter one (1) when the initial intake begins.
Treatment Committed	Enter one (1) when the treatment approval is complete.
Treatment Claim	Enter one (1) when the claim is complete.
Client Communication	Enter one (1) for each correspondence, communication, or interaction that provides client-centered assistance, either directly with the client or indirectly on behalf of the client, excluding face-to-face sessions with the client. This includes phone calls, voicemail, text messages, and e-mail. Face-to-face sessions should be captured as either general or home-based visits. One Unit = One Correspondence/Communication/Interaction.
Recertification	Enter (1) for each certification received from a client.

Support Services

Emergency Financial Assistance

HRSA Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist an RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including paying for utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:

- Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category.
- Direct cash payments to clients are not permitted.
- Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Goal: Assist clients with meeting a short-term urgent need for an item or service that is essential to their HIV care and treatment. Services and items could include, but are not limited to, the following:

- Utilities (*may include household utilities including gas, electricity, propane, water, and all required fees*)
- Housing (*may include rent or temporary shelter. EFA can only be used if HOPWA assistance is not available*)
- Food (i.e., groceries or food vouchers)
- Transportation (Taxi vouchers, Uber Health, Lyft Health, bus passes)
- Prescription medication assistance (i.e., short term or one-time assistance for any medication and associated dispensing fee as a result or component of a primary medical visit, and not to exceed a 30-day supply)
- Other RWHAP allowable costs needed to improve health outcomes
- Vision Care to pay the cost of corrective prescription eyewear for eligible clients

Agencies funded for EFA must be able to make an explicit connection between any service supported with EFA funds and the intended client's HIV care and treatment, or care-giving relationship WITH a person living with HIV.

Unallowable EFA Expenses:

- Security Deposits for rental housing
- Clothing
- Court Fees
- Maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle or any other costs associated with a car, such as a lease or loan payments, insurance, license and registration fees, towing, or impound fees, excise tax. This restriction does not apply to vehicles operated by organizations for program purposes.
- Local or state personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).

- Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
- Funeral and Burial Expenses

Objective: Agencies funded for EFA will assess the client's emergency needs related to food security, housing, utilities, transportation, and cost of medication, as well as provide appropriate assistance.

Subservice	Definition
EFA Voucher	Enter (1) after payment of service is complete or when a client receives a voucher. Mark the box that best describes the type of payment or voucher distributed: • **Housing**: Direct Payment to an agency to promote housing stabilization. • **Utility**: Direct Payment to an agency of a phone, sewer, water, heating, cooling, or electricity expense. • **Food**: The distribution of a food voucher. • **Medical Cost**: Is the direct payment to an agency or provision of medication that is not covered by ADAP or RWHAP cost. • **Other**: The Direct Payment to an agency or distribution of a voucher for a qualifying circumstance. These items must be included in the scopes of services or approved by a contract manager.

Food Bank & Home Delivered Meals

HRSA Description:
Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:

- Unallowable costs include household appliances, pet foods, and other non-essential products.
- See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

Goal: Prevent hunger and malnutrition among people living with HIV.

Objective: Improve access to food sources and improve nutrition for people living with HIV with identified food security needs.

Subservice	Definition
Home Delivered Food	Enter the number of meals or food items delivered to the house of a client or family that requires the service.
Hot Meals	Number of meals provided to the client in a group setting that is not the client's home.
Assessment, Nutritional	Enter one (1) when the nutritional assessment is complete.
Visit, General Nutritional Counseling	Enter one (1) for each face-to-face general nutritional counseling session between counselor and client. (does not include initial assessment) One Unit = One Hour.
Food Bank Package	Withdrawal from the food bank. Enter one (1) per can or package.

Housing

HRSA Description:
Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. The housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:

- HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.
- HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.
- Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits. However, these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Goal: Assist a client to gain or maintain medical care by reducing the barriers to permanent shelter and providing linkages to permanent housing.

Objective: Eligible clients will receive assistance in the form of individual sessions with a housing search advocate, or in the form of financial assistance within the parameters listed below.

Note: The following subservices are for both 'Housing-Rental Assistance' and 'Housing-Search & Advocacy.'

Subservice	Definition
Visit, Initial	First face-to-face housing session between provider and client. One Unit = One Hour.
Visit, Follow-up	Any non-initial housing session between provider and client. One Unit = One Hour.
Placement, Temporary	Enter one (1) for placing a client in temporary housing.
Placement, Permanent	Enter one (1) for placing a client in permanent housing.
Assessment, Completed	Enter one (1) when the assessment is complete.

Supported Referral	Enter (1) for each active process of connecting a client to any necessary HIV-related or supportive service (i.e., calling and making an appointment with a client, making an appointment on a client's behalf, etc.)
Housing Support, Group	Face-to-face sessions between an eligible provider and the client participating in a group session with three or more individuals. One Unit = One Hour.
Homelessness Prevention	Enter one (1) for each unit (month of payment) of Homelessness Prevention delivered.
Rental Start-Up	Enter the amount provided for the first month, last month, or both periods.
Application Processed	Enter one (1) for each Rental Assistance application reviewed.
Application Rejected	Enter one (1) for each Rental Assistance application rejected or denied.
Client Communication	Enter one (1) for each correspondence, communication, or interaction that provides client-centered assistance, either directly with the client or indirectly on behalf of the client, excluding face-to-face sessions with the client. This includes phone calls, voicemail, text messages, and e-mail. Face-to-face sessions should be captured as either general or home-based visits. One Unit = One Correspondence

Medical Transportation

HRSA Description:
Medical Transportation is the provision of non-emergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not, in any case, exceed the established rates for federal Programs (Federal Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems
- Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

Goal: Maintain clients connected to core medical and support services that contribute to positive health outcomes.
Objective: Provide allowable transportation resources to eligible clients who otherwise could not access the core and support services to meet medical and support needs.

Subservice	Definition
One-Way Ride, Public	Enter one (1) for each one-way transportation by a public transport system (subway or bus passes) for the client to access healthcare or support services.
One-Way Ride, Taxi/ Transportation Company	Enter one (1) for each one-way transportation by taxi or other transportation services for a client to access healthcare or support services.
One-Way Ride, Van	Enter one (1) for each one-way transportation by a funded agency vehicle for clients to access healthcare or support services.
One-Way Ride, Volunteer	Enter one (1) for each one-way transportation by a volunteer for a client to access healthcare or support services.

Non-Medical Case Management

HRSA Description:
Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention of needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients in obtaining access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every six months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:

- NMCM Services have as their objective to provide coordination, guidance, and assistance in improving access to and retention of needed medical and support services to mitigate and eliminate barriers to HIV care services. In contrast, Medical Case Management Services have as their objective improving health care outcomes.

Goal: Enhance access to and retention in essential medical and social support services for people living with HIV. This is a human service approach that supports engagement and retention in medical care.

Objective: Assess client needs and develop an Individual Service Plan (ISP) that provides guidance and assistance in improving access to needed services.

Subservice	Definition
Initial Intake, Started	Enter one (1) when the initial intake begins.
Assessment, Completed	Enter one (1) when the assessment is complete.
Visit, General	A face-to-face non-medical case management session between provider and client. One Unit = One Hour.

Visit, Home-Based	A face-to-face session between provider and client where case management services are provided in a non-office-based setting, including but not limited to residential settings. One Unit = One Hour.
Reassessment/Follow-up Service Plan, Completed	Enter one (1) when the reassessment/follow-up service plan is complete.
Supported Referral	Enter (1) for each active process of connecting a client to any necessary HIV-related or supportive service (i.e., calling and making an appointment with a client, making an appointment on a client's behalf, etc.).
Client Communication	Enter one (1) for each correspondence, communication, or interaction that provides client-centered assistance, either directly with the client or indirectly on behalf of the client, excluding face-to-face sessions with the client. This includes phone calls, voicemail, text messages, and e-mail. Face-to-face sessions should be captured as either general or home-based visits. One Unit = One Correspondence

Other Professional Services (Legal)

HRSA Description:
Other Professional Services allow for the provision of professional and consultant services rendered by members of professions licensed and/or qualified to offer such services by local governing authorities.

Legal services provided to and/or on behalf of the HRSA RWHAP-eligible people living with HIV and involving legal matters related to or arising from their HIV disease, including

- Assistance with public benefits
  - Unemployment compensation
  - Social Security Disability Insurance (SSDI)
  - Supplemental Nutrition Assistant Program (SNAP)
  - Supplemental Security Income (SSI)
  - Medicare & Medicaid
- Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
- Preparation of:
  - Durable Power of Attorney for Healthcare
  - Living will
  - General/Financial Power of Attorney
  - Last Will & Testament or Trust
  - Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
  - Legal Consultation Services (*not representation*) may also be available in these areas:
    - Debt collection and judgment process
    - Bankruptcy
    - Garnishment

Providers must be able to make an explicit connection between the legal service and the intended client's HIV care and treatment. They must be able to demonstrate that the service is necessary to improve the client's health outcomes.

Program Guidance:
Legal services exclude criminal defense, OUI, immigration, and class action lawsuits. A class-action lawsuit may be considered if related to access to services eligible for funding under the RWHAP.

Goal: Provide clients with access to legal services necessary to improve client health outcomes.

Objective: Reduce the effects of HIV discrimination, assist with access to and maintenance of medical care; remove barriers to accessing care, treatment, and services.

Subservice	Definition
Legal Services Assessment	Enter one (1) when the legal services assessment is completed.
Individual-level Legal Services	Document any time spent on a face-to-face or telephone encounter between provider and client during which legal services are provided. One Unit = One Hour.
Group-level Legal Services	Enter one (1) when the client has attended one (1) group.
Legal Case Work	Document any time spent on an activity related to the client's case, including research and document preparation. One Unit = One Hour.
Legal Representation	Document any time spent by the provider representing the client in court or at hearings. One Unit = One Hour.
Communication on Behalf of Client	Document any time spent in communication (face-to-face, phone, email, etc.) with another service provider on behalf of a client. One Unit = One Hour.

Psychosocial Support

HRSA Description:

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

- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:

- Funds under this service category may not be used to provide nutritional supplements (See Food Bank/Home Delivered Meals).
- HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.
- HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership.
- The psychosocial Support staff is not required to be people living with HIV.

Goal: Psychosocial support services will decrease isolation for people living with HIV and support the well-being of people living with HIV.

Objective: Through one-on-one interactions and in small groups, psychosocial support promotes clients' engagement in health care and emotional support in a respectful setting. Subrecipients of psychosocial support assist in the development of coping skills, reduce feelings of social isolation, increase self-determination and self-advocacy, helping improve the quality of life for participants.

Subservice	Definition
Support Session, Group	A regularly scheduled HIV support counseling meeting for three or more people affected by HIV. One Unit = One Hour.
Support Session, Individual	A face-to-face counseling session between staff and a person affected by HIV. One Unit = One Hour.

Policies and Procedures

The following is a comprehensive list of policies that your agency must maintain and can expect to submit to Ryan White Services during an annual site visit. RWS may request the submission of policies before the day of the site visit. The Contract Manager assigned to lead your site visit will help you determine how to organize the submission of policies.

Required Policies

Please familiarize yourself with this list and how each relates to your program and Ryan White Part A service category.

Program & Service Delivery Policies

- 2.0 Intake, Discharge, Transition & Case Closure
- 3.0 Linkage to Care, Client Retention & Client Reengagement
- 4.0 Staff Credentials Training & Supervision
- 5.0 Staff Safety Standards
- 6.0 File Maintenance & Data Security
- Service-Specific Policies

Fiscal Policies:

Audits

- Non-audited interim financial statements
- Audited financial statements
- Single Audit
- Risk Assessment

Imposition of Charges

- Fee Schedules
- Sliding Fee Schedule Policy
- Cap on Charges

Financial Policies and Procedure Manuals

- Fixed Assets Policy
- Billing and Collection Policy
- Purchasing Policy
- Travel Policy
- Hazard Pay Policy
- Gift Card Distribution and Tracking Policy and Procedures
- Tablet/Electronic Device Distribution and Tracking Policy and Procedures

Fiscal Policies and Financial Reports

- Accounting Policies and Procedures Manual
- Policy on revenue, including Program Income

- Policy and Procedures on the selection of an auditor
- 12-Month Report of Program Income
- Policy to determine Occupancy costs
- Policy to determine the reasonableness of cost
- Medicaid certificate
- Part A agreement and budget
- Chart of Accounts
- One Month invoices
- Agency income statement
- HHS indirect cost rate (if applicable)
- Summary of HIV Funding including Local, State, and Federal Revenues (HIV Funding Table)
- Quarterly payroll tax report
- IRS agreement for payment of taxes in arrears (if applicable)
- Insurance Policies – Certificate of Liability, Worker's Comp, Property Liability, Directors and Officers Liability, Automobile Liability.

Human Resources

- Employee Handbook
- Organizational Chart
- Fiscal Document Retention and Destruction Policy
- Whistle Blower Policy
- Board Minutes
- Governance that addresses insider transactions and conflicts of interest

Time and Effort Policy and Procedure

- One pay period payroll journal, timesheets, and effort reporting.

Payor of Last Resort Policy

Ryan White HIV/AIDS Program funds are the payer of last resort. Subrecipients must reasonably explore all other states and federal funding sources.

Specifically, federal policy requires:

- Do not use Ryan White HIV/AIDS Program funds to pay for Medicaid-covered services for Medicaid beneficiaries.
- Ryan White HIV/AIDS Program subrecipients who provide Medicaid-covered services must be Medicaid certified.
- Ryan White HIV/AIDS Program subrecipients must vigorously pursue Medicaid enrollment for individuals who are eligible for Medicaid coverage.
- Ryan White HIV/AIDS Program subrecipients must seek payment from Medicaid when they provide a Medicaid-covered service for a Medicaid beneficiary.
- Ryan White HIV/AIDS Program subrecipients must back bill Medicaid for any Ryan White Act-funded services provided to Medicaid-eligible clients once Medicaid eligibility is determined.

Subrecipients must exhaust mandatory Medicaid dollars before utilizing discretionary Ryan White HIV/AIDS Program funds. The Payor of Last Resort policy is currently part of all BPHC Part A provider contracts and all program budgets. If you have questions regarding these policies, please feel free to call our office.

Federal Monitoring Standards and Imposition of Charges

To guide the administration of the Ryan White Part A Program to ensure compliance with grant requirements related to charges to clients as per the following Health Resources Service Administration guidance:

- Ryan White Legislation:
  - §2605 (e)(F)(A)
  - §2605 (e)(1)(B)
  - §2065 (e)(1-4)(C-F)
- Part A Assurances
- HRSA FOA
- BPHC Ryan White Part A Contract
- National Monitoring Standards
- 45 CFR

Important Terms

Costs are the accrued expenditures incurred by the recipient /subrecipient during a given period requiring the provision of funds for (1) goods and other tangible property received; (2) services performed by employees, contractors, subrecipients, subcontractors, and other payees.

- **Charges** are the *imposition of fees* **upon payers** for the delivery of billable services.
- **Payments** are the collection of fees from payers that are applied to cover some aspects of the costs of billable services.
- **Billable services** are those for which there is a payer source.
- **Charge Master/Schedule of Charges** is a comprehensive listing of prices for billable services and procedures.
- **Sliding fee** means that costs change according to the patient's income, lack of income, or ability to pay.

Policy and Procedures

If the subrecipient charges health insurers for a service, the subrecipient must impose the same charge and provide a discount to uninsured clients using the service.

If an entity receiving Part A funds charges for services, it must do so on a sliding fee schedule that is available to the public and establish fees that are reasonable and necessary. Setting a fee schedule should not result in a bureaucratic system to means-test individuals or families before Part A supported services

are available. The sliding fee scale intends to protect clients from becoming so overwhelmed by financial burdens they leave the system. The sliding fee scale/schedule of charges shall not permit costs to clients with an income equal to or less than 100% FPL and permits nominal fees for clients with income >100% FPL.

1) Subrecipient/Subcontractor policies and procedures must specify charges to clients for services, which may include a documented decision to impose only a nominal charge Establish, document, and have available for review:
    a. Sliding fee discount policy
    b. Current fee schedule
    c. Sliding fee eligibility applications, in client files
    d. Fees charged and paid by clients
    e. Process for charging, obtaining, and documenting client charges through a medical practice information system, manual or electronic
2) No charges imposed on clients with incomes below 100% of the Federal Poverty Level (FPL)
    a. Document that:
        i. Sliding fee discount policy and schedule do not charge clients below 100% of FPL for services
        ii. Personnel are aware of and following the policy and fee schedule
        iii. Subrecipients must consistently practice the policy
3) Charges to clients with incomes higher than 100% of the federal poverty line must be discounted fee schedule and a sliding fee scale:
    a. Cap on total annual charges for Ryan White services based on the percent of the client's yearly income, as follows:
        i. 5% for patients with incomes between 100% and 200% of FPL
        ii. 7% for patients with incomes between 200% and 300% of FPL
        iii. 10% for patients with incomes higher than 300% of FPL
        iv. Clients earning less than 500% of FPL who can document that their out-of-pocket expenses exceed 10% of their income may submit an Eligibility Letter for Exceeding Charges Cap.
    b. Have in place a fee discount policy that includes a cap-on-charges policy and appropriate implementation, including:
        i. Annually evaluating clients to establish individual fees and caps
        ii. Track of Part A charges or medical expenses inclusive of enrollment fees, deductibles, co-payments, etc.
        iii. Have a process for alerting the billing system that the client has reached the cap and do not charge the client for the remainder of the year
        iv. Documentation of policies, fees, and implementation, including evidence that staff understand the policies and procedures

Unallowable Costs

All funded subrecipients must:

1) Maintain files with signed subrecipient agreements, assurances, and certifications that specify unallowable costs.
2) Provide and maintain budgets, expenditures, and related reports to BPHC with sufficient detail to document that they do not include unallowable costs.
3) Maintain on-file policies and documentation consistent with the following cost prohibitions:
    a. Cash payments to intended recipients of RWHAP services
    b. Clothing
    c. Developing materials that may be perceived to promote or encourage injection drug use
    d. Drug use and sexual activity
    e. Employment and Employment Readiness
    f. Funding liability risk pools
    g. Funeral, burial, cremation, or related expenses
    h. Household appliances
    i. International travel
    j. Local or State personal property taxes (for residential property, private automobiles, or any other personal property)
    k. Off-premises social/recreational activities or payments for a client's gym membership
    l. Pet foods or other non-essential products
    m. Pre-exposure prophylaxis and Non-Occupational Post-Exposure Prophylaxis
    n. Purchase of land, construction, or renovations
    o. Purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facilities.
    p. Purchase Vehicles without Approval
    q. Syringes

Property Standards

All funded subrecipients must:

1) Develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source.
2) Make a list and schedule available to the grantee upon request.
3) Provider/Subcontractor tracking of and reporting on tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part A funds and having a useful life of more than one year and an acquisition cost of $5,000 or more per unit.
4) Implementation of adequate safeguards for all capital assets that assure that they are used solely for authorized purposes.
5) Real property, equipment, intangible property, and debt instruments are acquired or improved with federal funds held in trust by subrecipients/subcontractors, with the title of the property vested in BPHC but with the federal government retaining a revisionary interest.
    a. Establish policies and procedures that acknowledge the revisionary interest of the federal government over property improved or purchased with federal dollars.
    b. Maintain file documentation of these policies and procedures for BPHC review.
6) Assurance by subrecipients/subcontractors that the title of the federally owned property remains vested in the federal government, and if the HHS awarding agency has no further need for the property, it will be declared excess and reported to the General Services Administration
7) Title to supplies to be vested in the recipient upon acquisition, with the provision that if there is

a residual inventory of unused supplies exceeding $5,000 in total aggregate value upon termination or completion of the program and the supplies are not needed for any other federally-sponsored program, the recipient shall retain the supplies for use on non-federally sponsored activities or sell them, and compensate the federal government for its share contributed to purchase of supplies.

a. Develop and maintain a current, complete, and accurate supply and medication inventory list.
b. Make a list available to BPHC upon request.

Income from Fees for Services Performed

Use of Part A and third-party funds to maximize program income from third-party sources and ensure that Ryan White is the payer of last resort. Third-party funding sources include Medicaid, State, Children's Health Insurance Programs (SCHIP), Medicare (including the Part D prescription drug benefit), and private insurance. The agency must have:

1) Ensure billing and collection from third-party payers, including Medicare and Medicaid so that payer of last resort requirements is met:
    a. Establish and consistently implement:
        i. Billing and collection policies and procedures
        ii. Billing and collection process or electronic system
2) Have policies and staff training to educate staff on the payor of last resort policies and systems that demonstrate compliance with the policies.
3) Require that each client be screened for insurance coverage and eligibility for third party programs, and helped to apply for such coverage, with documentation of this in client files.
4) Carry out internal reviews of files and billing system to ensure that Ryan White resources are used only when a third-party payer is not available.
5) Establish and maintain medical practice management systems for billing.
    a. Documentation of accounts receivable
6) Ensure provider/subcontractor participation in Medicaid and certification to receive Medicaid payment.
    a. Document and maintain file information on grantee or individual provider agency Medicaid status.
    b. Maintain a file of contracts with Medicaid insurance companies.
    c. If no Medicaid certification, document current efforts to obtain such certification.
7) Bill, track, and report to the grantee all program income (including drug rebates) billed and obtained.
8) Ensure service provider retention of program income derived from Ryan White-funded services. Funds may be added to resources committed to the project or program and used to further eligible project or program objectives, or used to cover program costs:
    a. Document billing and collection of programs income
    b. Report program income documented by charges, collections, and adjustment reports or by the application of a revenue allocation formula.

Limitations on Uses of Part A Funding

1) Adherence to a 10% cap on Administrative Expenses. Appropriate subrecipient administrative activities include:
    a. usual and recognized overhead activities, including established indirect rates for agencies.
    b. management oversight of specific programs funded under Ryan White; and
    c. other types of program support such as quality assurance, quality control, and related activities.
2) Inclusion of indirect costs
    a. Indirect costs (capped at 10%) are only where the subrecipient has a certified HHS-negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certificate of Indirect Costs
    b. Subrecipients wishing to include an indirect rate must provide documentation of the current Certificate of Cost Allocation Plan or Certificate of Indirect Costs that is HHS-negotiated, signed by an individual at a level no lower than the chief financial officer.[1]
    c. If using indirect cost as part or all its 10% administration costs, obtain and keep on file a federally approved HHS-negotiated Certificate of Cost Allocation Plan or Certificate of Indirect Costs
    d. Submit a current copy of the Certificate to the Boston Public Health Commission (BPHC)

[1] 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 subrecipients/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).

Authorization to Obtain/Release Information

Subrecipients must collect authorization to obtain/release information from a client before any communication with external partners about the client. Programs must have a release of information form that describes under what circumstances client information can be released. The subrecipient must document each entity client information will be sent, the specific information to be shared, the client signature and date signed, and provide space for revocation of the authorization. **All authorizations to obtain/release information expire 12 months from the date of the signature.**

Documentation of multiple external partners is allowable on one form. At any point in time, clients reserve the right to revoke authorization to obtain/release information. If the client revokes an authorization form, the subrecipient cannot communicate with all external partners included in the authorization form. A new form must be completed with the client's initials next to each entity as well as a signature of authorization.

This form can be used as a living document. Over time clients may want to allow the release of information to additional entities. This is allowable so long as the agency ensures the client's initials accordingly. There will be no change to the expiration of one year. All releases will expire at the date listed at the bottom of the page. The date listed cannot be changed. There is no extension of the release of information. At the end of one year, the agency needs to work with the client to obtain a new signed and initialed form.

Required Elements of Authorization

- ☐ Client ID
- ☐ The entity to be shared (specific staff person, when possible)
- ☐ Contact information (phone/fax/address or location?)
- ☐ Date signed
- ☐ Date of expiration (No more than 12 months)
- ☐ Staff Signature
- ☐ Client Signature
- ☐ Client Initials identifying each specific authorization to each external agency

Revoked Authorization

- ☐ Client Signature
- ☐ Date
- ☐ Staff Initials

Optional

- ☐ Emergency Contact

- Name
- Relationship
- Contact Information

Agency Incident/Grievance Report Procedures

RWS requests that agency staff report major incidents/grievances as soon as possible after the event to their contract managers.

Examples of significant incidents/grievances which should be reported include, **but are not limited to, the following:**

- Physical harm or threat of physical harm to a client or staff member
- Significant structural damage to agency premises (such as a fire or flood)
- Involvement of external law enforcement or emergency personnel
- Breaches in client confidentiality

The report should include the following information:

- Reporting staff name
- Date of incident/grievance
- A detailed description of what happened, the outcome, and needed-follow-up

The purpose of this report is to alert contract managers to situations that cause stress to clients and staff and may temporarily impact services provided by the agency. These reports also allow RWS to offer support and guidance where appropriate. RWS requests the program to complete this form for our internal tracking purposes only. Please see the Sample Forms section for a sample Incident Report Form.

Contract Termination Policy

At the end of a contract period, every vendor holding a Ryan White Part A contract with the Boston Public Health Commission (BPHC) Ryan White Services is responsible for ensuring the resolution of any outstanding agreement related issues. This policy applies in all instances of contract termination, regardless of the reason for the termination.

Clients/Client Records (*applicable only if services will not continue at the agency*)

1) The vendor shall notify all clients affected by the contract termination that services will no longer be provided. Such notification shall be provided at least 30 days before the contract termination date. The vendor should make every effort to notify clients in person. If in-person notification is not feasible, clients should be notified in writing via certified mail with a return receipt. If a return receipt is not delivered within two weeks, a follow-up notice should be sent via regular mail. The notice should include a list of other agencies in the same geographic area that provide the same or similar services.
2) Whenever practicable, the vendor should assist each client with registration for services at another agency of the client's choosing. This will necessarily include the transfer of client records, whether maintained on paper or in electronic media, which must be undertaken

following the terms of the confidentiality agreement entered into at the time of contract execution.
3) If a client does not wish for his or her records to be transferred to another agency, the vendor is responsible for the confidential storage of these records, per State and Federal laws.

Data

1) No more than 15 days after the contract termination date, vendors must submit all client-level data collected for purposes of the contract (including data from subcontracted agencies) up to the contract termination date. Data submissions must be made in the same manner as they had been during the contract period.

Reporting

1) No more than 30 days after the contract termination, unless the contract manager directs otherwise, vendors must submit a final Progress Report covering the period between the previous submission and the contract termination date. This includes both narrative and data submissions.
2) Vendors must submit a Ryan White HIV/AIDS Program Services Report (RSR) covering the period between the previous RSR submission and the contract termination date. The submission date for the RSR is on an annual basis following the end of each calendar year. If this is impossible, the vendor must work with BPHC staff to ensure that the information needed to complete the RSR is available to BPHC.

Fiscal

1) No more than 15 days after the contract termination date, the vendor will submit any final billing.

Purchased Items

1) Program supplies paid for under the contract remain the property of the vendor.
2) Capital and equipment purchases made with funds allocated under the contract are the property of BPHC unless such capital items have fully depreciated, in which case they remain the property of the vendor. If an item has not fully depreciated, BPHC will determine whether the item must be returned to BPHC or transferred to another vendor.

Data Importing Policy

Effective Date
September 1, 2024

Last Revision Date
July 17, 2024

1.0 Introduction

1.1 Overview

This document provides a comprehensive outline of the eligibility requirements, data importing process, and expectations pertaining to the transfer of data from the internal databases of Ryan White HIV/AIDS Part A & MAI subrecipients to e2Boston.

1.2 Purpose of Policy

The Data Importing Policy serves to enhance the data quality within the Boston EMA. By introducing this policy, our objective is to mitigate duplicative data entry in subrecipients' internal databases and e2Boston. For eligible subrecipients, the data importing process facilitates the efficient transfer of RWHAP Part A & MAI programmatic data from databases.

1.3 Scope

This policy applies to all RWHAP Part A & MAI subrecipients within the Boston Eligible Metropolitan Area who meet the eligibility criteria outlined in Section 3.1 (Eligibility Requirements).

2.0 Policy Statement

Eligible RWHAP Part A & MAI subrecipients within the Boston EMA have the option to import client-level programmatic data from their internal databases to e2Boston, provided that the data importing process complies with RWS's requirements and guidelines.

3.0 Policy Details

3.1 Eligibility Requirements

Ryan White HIV/AIDS Part A & MAI subrecipients may request access to import required programmatic data into e2Boston, contingent upon their agency meeting the following criteria:

1) Data Infrastructure Capacity
    a. An average minimum of 100 clients annually utilizing Part A & MAI services
    b. Utilization of an Electronic Health Record (EHR) for each Part A & MAI client
    c. Capacity to cover all expenses associated with data importing
    d. Note: This includes creating the agency's own data importing bridge or accessing the existing e2Boston importing engine
2) Staff Infrastructure Capacity
    a. Designated personnel responsible for data importing
        i. Note: The agency must maintain at least one staff member to perform this duty and ensure subsequent staff are trained in data importing procedures
        ii. Agency responsibility statement: It is the responsibility of the agency to train new and retained staff on the system and data importing module. BPHC ***will not*** be providing training in the future on this topic.
3) History of Data Quality
    a. Demonstrated history of completeness of Part A & MAI programmatic data
    b. Demonstrated history of accuracy of Part A & MAI programmatic data
4) History of Timely Data Submission
    a. Demonstrated history of timely submission of Part A & MAI programmatic data by required deadlines

3.2 Explanation of Importing Mechanism

RWHAP Part A subrecipients interested in importing programmatic data must contact RWS (refer to Section 4.0 Contacts) and adhere to the following procedural outline to obtain data importation access:

1) Upon expressing interest, RWS's Data Manager will provide subrecipients with eligibility criteria and the application to assess their suitability for data importing.
2) Subrecipients will utilize these tools to determine eligibility and subsequently submit their findings to RWS's Data Manager for review.
3) If subrecipients are deemed ineligible, they will continue manual data entry into e2Boston. If subrecipients meet the eligibility criteria, they will submit a proposal to RWS's Data Manager outlining how they will update user access in e2Boston.
4) Subrecipients opting to develop their own data transfer method will independently finance a contract with RDE to construct a bridge between systems. Alternatively, those opting to utilize the e2Boston engine will use the provided e2Boston template and format data according to the Required Data Elements tool available in e2Boston.
5) Once the bridge is established and the Data Import Tab is integrated, subrecipients will gain the ability to import files into e2Boston.
6) If there are errors after importing files into the Data Import Tab, subrecipients must rectify the data within their internal databases and re-import the revised data.
7) If the imported data is accurate, subrecipients will click submit and the data importing process will be considered complete.
8) Subrecipients will then receive an email from RWS confirming the successful completion of the data importation process.

3.3 Importing Expectations

Ryan White HIV/AIDS Part A subrecipients are required to adhere to the following data importation guidelines:

1) Data Content
    a. All updates to client-level data (i.e., Eligibility Information, H&I, Demographics, Viral Load, etc.)
    b. All service and utilization data
2) Frequency
    a. Importation should occur once a month
        i. Note: Monthly data importation is necessary for all clients with updated information, regardless of the client's outcomes submission clock.
3) Financial and Data Management
    a. Subrecipients are responsible for covering all expenses associated with the implementation and maintenance of the data importation system bridge
        i. Note: This is regardless of which importing machine is utilized

3.4 Assuring Policy Compliance

RWS personnel will routinely monitor subrecipients' adherence to data importing procedures and maintenance of satisfactory data quality. The primary goal of this monitoring is to mitigate instances of missing, late, and/or incomplete data from subrecipients utilizing the importing module.

In the event that subrecipients are unable to uphold the importing expectations outlined in Section 3.3, they will receive a non-compliance warning. These warnings will be issued to subrecipients with

inadequate data importing compliance on a quarterly basis. Subsequently, subrecipients will be granted a 30- or 60-day window to rectify the issues identified in the warning. Upon receipt of three non-compliance warnings, subrecipients' data importing access will be revoked.

Furthermore, RWS will conduct an annual evaluation of all non-compliance issues among subrecipients utilizing the data importing module. Similarly, subrecipients failing to meet the data importing expectations consistently throughout the fiscal year will receive non-compliance warnings at year-end. Subrecipients will have a 30-day period to address the findings. Failure to adequately rectify the findings will result in the revocation of the importing module from subrecipients.

4.0 Contacts

1) Ryan White Services
    a. RyanWhiteServices@bphc.org

2) Clinical Quality Management Team
    a. cqm@bphc.org

3) e2Boston Support Team
    a. support@e2Boston.net

Transitioning Clients from EHE to Part A

The Infectious Disease Bureau formulated the following to explain eligibility criteria and requirements to transition from the End the HIV Epidemic (EHE) funding program to the Ryan White Part A funded program. The following information will help guide you on how to transition PLWH/A to the Ryan White Part A Program from the Ending HIV Program once they qualify for RW.

Differences between EHE and Part A:

EHE	Part A
Newly diagnosed with HIV/AIDS	HIV/AIDS Diagnosis
Suffolk County Residency	Boston EMA Residency
People who are not virally suppressed	Income status 500% below the FPL (Federal poverty line)
People who are disengaged or not connected to care	Insurance verification
Initiative Services and Infrastructure	Recertification Required every 12 months

EHE Services	Ryan White HIV/AIDS Program (RWHAP) Services
Costs associated with a broader approach to addressing HIV in the community than exists in services authorized by the RWHAP legislation	Costs associated with the provision of core medical and support services to initiative-eligible clients

Initiative services (e.g., linkage to care) are services and activities that do not fit neatly within the RWHAP service categories	Services must relate to HIV diagnosis, care, and support, and follow established clinical practice standards consistent with HHS HIV treatment guidelines
These services may be innovative and creative with a focus on ending the HIV epidemic	Must comply with PCN 16-02
In some instances, prior approval is needed	In some instances, prior approval is needed
EHE initiative services (cost category) allow programs to stretch beyond the boundaries of traditional RWHAP to creatively meet EHE goals	Agencies must comply with Administrative costs associated with the budgets
Clients with HIV who aren't eligible for RWHAP may still receive services funded by EHE	
Incentives for EHE are limited to Early Intervention Services(EIS), Health Education and Risk Reduction (HERR), Medical Case Management (MCM) and Outreach Services (OS)	

Transitioning a PLWH/A from EHE to RW Part A Program

Newly diagnosed People Living With HIV/AIDS don't immediately qualify for the Ryan White Part A Program (RWHAP). Please see the information above to note the requirements of EHE versus the requirements of RWHAP. Case Managers must be aware of these key differences when making referrals for PLWH/A.

The Ending HIV Epidemic grant is used to establish testing and provide medication and initiative services, but it's only for Suffolk County. Please see the following list for scenarios where a PLWH/A should be referred to RWHAP:

1) After a PLWH/A has been in the program for a year, they are no longer newly diagnosed and need to be transitioned out of the program if they are eligible for Ryan White Part A.
2) PLWH/A relocating out of Suffolk County but still within Boston EMA:
   - Seven Counties in Massachusetts (Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester), and
   - Three Counties in New Hampshire (Hillsborough, Rockingham, and Strafford).
3) After a PLWH/A is virally suppressed, they are no longer in need of EHE
4) After a PLWH/A is connected and retained in care

The Medical Case Managers or supervisors working with the PLWH/A must ensure they follow the following procedure in the referral process for client transition and/or discharge.

1) The PLWH/A must use Part A eligibility requirements with their case manager to determine their eligibility and ability to transition to the RWHAP.
2) All required information will be assessed and submitted with the referral documentation
3) If the services provided to the PLWH/A are within the Boston EMA, the case manager will do what is necessary to keep the PLWH/A connected to the core and/or supportive services they are presently using if that is the preference of the PLWH/A.

All the necessary documentation and decisions made on behalf of PLWH/A must be thoroughly recorded and made accessible through the electronic database in use.

To ensure high-quality referrals and transfers, these transfer decisions must be checked over by a peer reviewer or supervisor before being submitted.

Sample Forms

Please see the following sample forms to aid program management and maintenance.

Annual Recertification Form

The purpose of this form is to document eligibility for the Ryan White HIV/AIDS Program services. Service providers can share the form to verify Ryan White Part A Client's eligibility. *This form is valid for one year (12 months).*

NOTE: The format of this document is optional and is just one way an agency may choose to document client eligibility. This template can be used to upload into e2Boston as the Annual Recertification form.

Agency Name:	
Agency Staff:	
Client Name:	
Client Code:	**Client UCI:**
Signature/Effective Date:	**Expiration Date (12 months after):**

Annual Recertification:

Annual Recertification must be collected once every 12 months to update/upload a client's eligibility for Ryan White Part A services. This includes:

- Income Verification
- Residency Verification
- Insurance Status

Income Verification Document

Please select one (1) of the income verification documents:

- ☐ Paystub(s)
- ☐ Safety net correspondence (IESSA, SNAP, etc.)
- ☐ Attestation/Affidavit signed by the Client (For instances of homelessness and/or other extenuating circumstances)
- ☐ HDAP Approval Letter
- ☐ PMI (Patient Medical Information)
- ☐ Bank Statement (s)
- ☐ Unemployment income
- ☐ Attestation/Affidavit (to states no income)
- ☐ Tax Return

Residency Verification Document

Please select one (1) of the residency verification documents:

- ☐ Utility Bill
- ☐ Official Correspondence from Government Agency
- ☐ Paystub(s)
- ☐ Insurance verification document
- ☐ PMI (Patient Medical Information)
- ☐ Attestation/Affidavit signed by the Client (For instances of homelessness and/or other extenuating circumstances)
- ☐ License (not expired)
- ☐ Rental agreement
- ☐ Voter Registration
- ☐ Tax return
- ☐ SSI/SSDI Statement

Insurance Verification Document

Please select one (1) of the insurance verification documents:

- ☐ EOB/EOP from insurance
- ☐ Letter verifying status from insurance
- ☐ Premium payment bill
- ☐ Virtual Gateway/Any 3rd party portal printout
- ☐ Health Insurance card (Medicare/Medicaid/ etc.)
- ☐ HDAP Approval letter

Client Signature:_____

Date:_____

Ryan White Services
Agency Incident/Grievance Report Form
Fiscal Year 2025

Boston Public Health Commission | Client Services | Infectious Disease Bureau | 1010 Massachusetts Ave., 2nd Floor | Boston, MA 02118

BPHC requests that agency staff report major incidents/grievances separately from the narrative reports submitted quarterly, and as soon as possible after the notice. The report should include the reporting staff name, the date of the incident, and a description of the scenario. In addition to alerting the agency's assigned contract manager to situations that cause stress to clients and staff, and may temporarily limit the services provided by the agency, these reports will also allow BPHC to offer support and guidance where appropriate. BPHC requests the program complete this form for the BPHC's internal tracking proposes only.

Incidents not limited to: Physical harm or threat to client or staff; significant structural damage to agency premises (such as fire or flood); and involvement of external law enforcement or emergency personnel.

Date of Incident:

Agency and Service Category, if appliable:

Name and Title of Person Filling Report:

Phone Number: **Email:**

Please describe all known details of the incident, noting the place, date, and relevant staff and clients involved. If this incident is part of an ongoing issue, please note that as well. If part of a present situation, any action taken as a result of the incident, and proposed next steps. Attach Additional pages as needed.

Ryan White HIV/AIDS Program, Part A

Boston Public Health Commission

Ryan White Services

Consent and Authorization to Share Information

I. Introduction

_____ (AGENCY) is part of a health network of care that provides one or more HIV services (Ryan White Part A and the Minority AIDS Initiative) within counties of Massachusetts (Middlesex, Essex, Suffolk, Worcester, Norfolk, Plymouth, and Bristol) and New Hampshire (Stratford, Rockingham, and Hillsborough) as part of the Eligible Metropolitan Area funded by the Boston Public Health Commission (later referenced as the Network). The healthcare agencies participating in the Network are listed below in sections III and IV.

Agencies within the Network frequently work together to provide referrals to each other for services that they may not provide in-house. For this reason, there may be a need to share your health information between two or more agencies. The purpose of this document is to consent to this sharing of data if you wish to seek services at two or more agencies, or to revoke this sharing of data if you no longer wish to seek services at those agencies.

II. Data Sharing

The management of your health information is made possible through a program called eCOMPAS (or E2Boston), which stands for Electronic Comprehensive Outcomes Measurement Program for Accountability & Success. In the course of providing your care, the Agency will collect and retain certain information about you, your health, and the services or treatment that are provided. This information is necessary to coordinate care appropriately, document and evaluate services rendered, and assess your health outcomes, which is required by the Health Resources and Services Administration, which funds the Ryan White Part A federal grant program.

Identified Information

Identifiable information that may be shared between agencies includes your demographic data, Social Security Number, contact information, financial/employment/socioeconomic data, insurance information, assigned client identification code, and record(s) of HIV/AIDS diagnosis and/or status.

De-identified Information

In order to monitor agency contracts as members of the Network, the above identifiable information may be de-identified and accessible to the Funding Source, the Boston Public Health Commission as the Ryan White Recipient, their program and administrative staff or consultants, and RDE System, who provide the software and technical support for the e2Boston system.

III. Consenting to the Sharing of Data

☐ I do hereby consent to and authorize _____ (AGENCY) to select Ryan White Providers below

for which I am a client of, or will be, to input and/or access the following electronic information: demographic data, Social Security Number, contact information, financial/employment/socioeconomic data, insurance information, assigned client identification code, and record(s) of HIV/AIDS diagnosis and/or status. I acknowledge by signing this form that these selected agencies, which are Ryan White contracted providers, will need my exact name and date of birth, or my exact social security number to access my information. I allow access to the electronic information described in the previous statement, to the following:

Choose *one or more* of the following agencies by State:

Massachusetts

☐ AIDS Project Worcester

☐ Beth Israel Deaconess Hospital

☐ Boston Children's Hospital

☐ Boston Health Care for the Homeless

☐ Cambridge Health Alliance

☐ Casa Esperanza

☐ ~~Catholic Charities of Boston*~~

☐ Codman Square Health Center

☐ Community Research Initiative

☐ Community Servings

☐ Dimock Community Health Center

☐ Edward M. Kennedy

☐ Father Bill's & MainSpring

☐ Fenway Community Health Center

☐ Greater Lawrence Family Health Center

☐ Harbor Health Services

☐ Harvard Street Community Health Center

☐ Justice Resource Institute

☐ Lynn Community Health Center

☐ Making Opportunity Count

☐ Mass. Alliance of Portuguese Speakers

☐ MGH Boston

☐ MGH Chelsea

☐ Multicultural AIDS Coalition

☐ NeighborHealth Community Health Center

☐ Ryan White Dental Program

☐ Upham's Community Health Center

☐ Victory Programs, Inc.

☐ Whittier Street Health Center

New Hampshire

☐ AIDS Response Seacoast

☐ Harbor Care

☐ New Hampshire Department of Health and Human Services

☐ Merrimack Valley Assistance Program

You may choose not to have your medical information shared with any other agency within the Network:

☐ I do not give permission for the Agency to share my health information.

IV. Revoking the Sharing of Data

☐ I hereby permit _____ (AGENCY) to revoke the authorization to share information with the following agencies in the Network and related services for which I was previously allowed to use and disclose identifying information to determine my eligibility to receive services. **I understand that a revocation is not effective to the extent that any Ryan White Part A provider has already acted in reliance on my previous authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the subrecipient or recipient and may no longer be protected by federal or state law.** I revoke the authorization to share information from the following:

Choose *one or more* of the following agencies by State:

Massachusetts

☐ AIDS Project Worcester

☐ Beth Israel Deaconess Hospital

☐ Boston Children's Hospital

☐ Boston Health Care for the Homeless

☐ Cambridge Health Alliance

☐ Casa Esperanza

☐ ~~Catholic Charities of Boston*~~

☐ Codman Square Health Center

☐ Community Research Initiative

☐ Community Servings

☐ Dimock Community Health Center

☐ Edward M. Kennedy

☐ Father Bill's & MainSpring

☐ Fenway Community Health Center

☐ Greater Lawrence Family Health Center

☐ Harbor Health Services

☐ Harvard Street Community Health Center

☐ Justice Resource Institute

☐ Lynn Community Health Center

☐ Making Opportunity Count

☐ Mass. Alliance of Portuguese Speakers

☐ MGH Boston

☐ MGH Chelsea

☐ Multicultural AIDS Coalition

☐ NeighborHealth Community Health Center

☐ Ryan White Dental Program

☐ Upham's Community Health Center

☐ Victory Programs, Inc.

☐ Whittier Street Health Center

New Hampshire

☐ AIDS Response Seacoast

☐ Harbor Care

☐ New Hampshire Department of Health and Human Services

☐ Merrimack Valley Assistance Program

V. Terms of the Consent Form

This consent will remain valid for one year or until revoked by me. If I revoke this consent form, I understand that I must do so in writing and that I must resubmit this authorization form indicating my revocation to an agency within the Network. I understand that the revocation will not apply to Health Information that has been released before the revocation. A written revocation will be effective five (5) days after the Ryan White Program Manager receives it. Services rendered after the date of revocation will not be paid for by the Ryan White Part A program.

I hereby hold the Boston Public Health Commission harmless for the disclosure and/or release of my ***private*** Health Information ***(pursuant to Federal Health Insurance Portability and Accountability Act "HIPAA" regulations)*** to any Ryan White contracted provider or the Health Resources and Services Administration (Funding Source) in connection with the Ryan White Program. I understand that my name, address, and other controlled identifiers are placed into the system.

I have a right to request relevant health information that is tracked in the system.

If the signer is a guardian, legal documentation of the representative's identity and authority to act on the individual's behalf must be attached. For a minor, the parent must attach a copy of the birth certificate to this form.

I further expressly consent to give the Boston Public Health Commission, and the Funding Source access to any records stored in the system and any other records held by any Ryan White Part A contracted agency for monitoring, reporting, operating, payment, and administration. A list of

service providers will be updated annually (if any new agency is contracted as a Ryan White Part A provider). I stipulate reproductions of this written consent are authentic as the original.

_____	_____
Client/Representative Signature	Self or Representative's Relation to Client
_____	_____
Witness	Date

BOSTON PUBLIC HEALTH COMMISSION

Ryan White Services
Budget Revision Request Form
Fiscal Year 2025

Agency	
Service Category	
Date of Request	

1. **Direct Care Costs: Change of Position, FTE, Salary, and Titles:** Include only the adjustment, removal, or addition of employee(s). Complete the Budget Revision Excel Form to account for financial adjustments. <u>Do not include additional lines created from line-item splits in the Excel document on this form. Use the Drop-Down Menu to indicate a line was split for the respective position.</u>

Line Split	Line Split Reason	Personnel Name	Position	Start	End	Reason for Adjustment	Supporting Documents Attached?
☐Yes ☐No	Choose an item.			Click or tap to enter a date.	Click or tap to enter a date.		☐
☐Yes ☐No	Choose an item.			Click or tap to enter a date.	Click or tap to enter a date.		☐
☐Yes ☐No	Choose an item.			Click or tap to enter a date.	Click or tap to enter a date.		☐
☐Yes ☐No	Choose an item.			Click or tap to enter a date.	Click or tap to enter a date.		☐
☐Yes ☐No	Choose an item.			Click or tap to enter a date.	Click or tap to enter a date.		☐
☐Yes ☐No	Choose an item.			Click or tap to enter a date.	Click or tap to enter a date.		☐
☐Yes ☐No	Choose an item.			Click or tap to	Click or tap to		☐

				enter a date.	enter a date.		

2. **Changes to Other Direct Service or Indirect Service Lines:** Include any budgetary adjustments.

Line Item/ Position	Personnel Name *(If applicable)*	Line Split	Line Split Reason	Start	End	Current Budget	New Budget	Reason for Change	Supporting Documents Attached?
		☐Yes ☐No	Choose an item.	Click or tap to enter a date.	Click or tap to enter a date.				☐
		☐Yes ☐No	Choose an item.	Click or tap to enter a date.	Click or tap to enter a date.				☐
		☐Yes ☐No	Choose an item.	Click or tap to enter a date.	Click or tap to enter a date.				☐
		☐Yes ☐No	Choose an item.	Click or tap to enter a date.	Click or tap to enter a date.				☐
		☐Yes ☐No	Choose an item.	Click or tap to enter a date.	Click or tap to enter a date.				☐
		☐Yes ☐No	Choose an item.	Click or tap to enter a date.	Click or tap to enter a date.				☐
		☐Yes ☐No	Choose an item.	Click or tap to enter a date.	Click or tap to enter a date.				☐

		☐Yes ☐No	Choose an item.	Click or tap to enter a date.	Click or tap to enter a date.				☐
		☐Yes ☐No	Choose an item.	Click or tap to enter a date.	Click or tap to enter a date.				☐
		☐Yes ☐No	Choose an item.	Click or tap to enter a date.	Click or tap to enter a date.				☐

3. **Signatures:** Sign this document by completing the section below.

Name of Authorized Representative	
Title	
Email	
Signature	

Budget Revision Example

Boston Public Health Commission
RYAN WHITE PART A: ALN 93.914
FY 2025
March 1, 2025 - February 28, 2026
AGENCY NAME
MEDICAL CASE MANAGEMENT

Budget Revision Request

Core/Support Service Direct Cost	Personnel	Salary	FTE	Months	Annual	Change	New Salary	New FTE	New Months	New Annual
Program Director	B. Smith	$50,000	0.50	12	$25,000	($7,008)	$50,000	0.36	12	$17,992
Medical Case Manager	K. Jones	$45,000	1.00	12	$45,000	$0	$45,000	1.00	12	$45,000
Medical Case Manager	J. Doe	$41,000	0.80	12	$32,800	$8,200	$41,000	1.00	12	$41,000
SUBTOTAL			2.30		$102,800	$1,192	**SUBTOTAL**	2.36		$103,992
FRINGE			30.00%		$30,840	$358	**FRINGE**	30.00%		$31,198
PERSONNEL TOTAL					$133,640	$1,550	**PERSONNEL TOTAL**			$135,190
Other Direct Care Cost							**Other Direct Care Cost**			
Staff Training					$1,000	($750)	Staff Training			$250
Staff Travel					$200	$0	Staff Travel			$200
Program Supplies					$1,000	($800)	Program Supplies			$200
SUBTOTAL					$2,200	($1,550)				$650
DIRECT CARE TOTAL					$135,840	$0				$135,840

Administrative Cost	Personnel	Salary	FTE	Months	Annual		New Salary	New FTE	New Months	New Annual
Program Director	B. Smith	$50,000	0.15	12	$7,500	$0	$50,000	0.15	12	$7,500
Program Rent (8% of total rent)					$6,084	$0				$6,084
ADMIN COST TOTAL					$13,584	$0	**EXPENSE TOTAL**			$13,584
DIRECT CARE TOTAL					$135,840	$0	**DIRECT CARE TOTAL**			$135,840
ADMINISTRATIVE COST					$13,584	$0	**ADMINISTRATIVE COST**			$13,584
SERVICE AWARD TOTAL					**$149,424**	$0	**SERVICE AWARD TOTAL**			**$149,424**

In this example, Medical Case Manager Doe's FTE changed from 0.80 to 1 for the year. The subrecipient has decided to decrease the Program Director's FTE from 0.50 to .36 on the Part A contract to make up for the additional funds needed for Doe. The subrecipient also had to reduce the Staff Training line to $250 and the Program Supplies line to $200. The subrecipient's original budget is reflected in the first six columns. Staff names may be added if the new staff has been hired.

The following are terms related to budget revisions. "Change" is the difference between the Annual and the New Annual (Change = Annual - New Annual). "New Salary" is the Full-Time Equivalent (1 FTE total) salary. If there is a salary adjustment from the original "Salary," back-up documentation is required (e.g., hire letter). "New FTE" is the new percentage of time that the position listed will be paid through this contract. "New Months" indicates the new number of months that the employee will work; the amount would differ from the original budget when a staff person is added or removed from a budget based on hiring or departure. "New Annual" is the updated total salary amount that will be paid for by Part A based on changes made to the salary, FTE, or months in the budget revision. "New Annual" for a staff member who is being removed from a budget must be the actual amount expended based on monthly invoices submitted to date.

Client Summary Form

The purpose of this form is to document financial eligibility for the Ryan White HIV/AIDS Program services. The form can be shared among service providers to verify income screening if the client has signed and dated a release of information document. *This form is valid for twelve months (1 year) after the screening date. NOTE: This form is optional and is just one way an agency may choose to document client income eligibility.*

Agency name:	
Agency address:	
Agency phone number:	
Client name:	**Client Code:**
Screening date:	**Expiration date twelve months after screening):**

Annual income:

Annual income is collected to determine the client's yearly gross income. The Client's income must be less than 500% of the FPL to be eligible for services. If the client provides a pay stub, use the gross year-to-date ("YTD") to calculate gross annual income. If the pay stub does not show total YTD, the client must provide two pay stubs, so that yearly gross earnings to calculate the client's average earnings for the designated pay period. The client must submit documents if they are not working but receive SSI, SSDI, or any other type of monetary benefit. If the client is not working and has no income, or if he/she is working but cannot provide proof of this, a letter from the client's medical case manager is required. If the client does not have a medical case manager, then a letter from his/her clinician is needed.

CLIENT ANNUAL INCOME: $_____

The documentation provided for client records (check all that apply):

☐ Paystub(s)

☐ Social Security Administration (SSDI/SSI) letter

☐ Private disability statement

☐ Department of Transitional Assistance (TANF/EAEDC) letter

☐ Veterans' Benefits

☐ Other: _____

Federal Poverty Level:

Consult the U.S. Department of Health and Human Services poverty guidelines for the current calendar year at http://aspe.hhs.gov/poverty. Based on the client's gross annual income, what is the applicable Federal Poverty Level (FPL) range **FPL:_____%**

Signature: _____

Date:_____

Eligibility Letter for Exceeding Charges Cap

[agency letterhead]

DATE

To Whom It May Concern:

I, _____, receive [services] through Ryan White from [agency name]. I earn [insert income] per year, which is <500% of the FPL. My documented out-of-pocket expenses have presently exceeded 10% of my income.

If you have any further questions, please call me at 000-000-0000.

Thank you for your assistance.

Medical Case Manager /Health Care Provider Signature Here Date:

Medical Case Manager/Health Care Provider Printed Name Here

Agency Name Here

Patient/Client Signature Here Date:

Patient/Client Printed Name Here

Hardship Waiver/No Income Letter

[agency letterhead]

DATE

To Whom It May Concern:

I, _____, receive [services] through Ryan White from [agency name]. I am currently making [insert income] and am unable to pay for [insert service type] due to financial hardship.

If you have any further questions, please call me at 000-000-0000.

Thank you for your assistance.

Medical Case Manager /Health Care Provider Signature Here Date:

Medical Case Manager/Health Care Provider Printed Name Here

Agency Name Here

Patient/Client Signature Here Date:

Patient/Client Printed Name Here

Ryan White Dental Program Application

To access the application in English, please click the photo below. Applications are available in **Spanish, Haitian, Creole, and Portuguese** as well.

03/19/2025

Enclosed you will find the client enrollment forms for the Ryan White Dental Program (RWDP). Please complete all information to the best of your ability. **WE ARE NOW REQUIRED TO COLLECT FINANCIAL, MEDICAL INSURANCE, AND RESIDENCY VERIFICATIONS EVERY TWELVE MONTHS FOR ACTIVE CLIENTS.**

Re-certification applications sent earlier than 30 days before the previous expiration date will not be processed, you will be notified, and the application will be destroyed.

In order to receive services from the RWDP, clients must be diagnosed with HIV/AIDS and reside in Massachusetts or the three southeastern counties of New Hampshire. Anyone regardless of income can be advised and referred to a dentist. If the client needs financial assistance their gross annual income must not exceed 500% of the federal poverty level (2025: $78,250; add $27,500 per dependent.)

If a client has MassHealth, they are required to see a dentist who accepts MassHealth. If a client has private dental insurance, the RWDP cannot pay for any co-payments and remaining balances. These are the guidelines outlined in our grant, and they are strictly enforced.

Before making a dental appointment, YOU MUST CONFIRM your eligibility and the participation status of the dental office. The program has special arrangements with contracted dentists, and referrals should come directly from our staff. Dental offices may have policies against no-shows, late fees, and other penalties for no-show, no-call appointments. RWDP cannot reimburse you for these costs. It is highly advised to be in communication with your dental office about scheduling issues.

Once an application is approved a letter will be sent explaining the dates of coverage. If a client would like mail sent to the case manager, please provide the case manager's address in the "Mailing Address" line.

Applications may be submitted to us via fax or mail. Please feel free to contact us if you have any questions. Program information and forms can also be found at boston.gov/bphc-rwdp.

Ryan White Dental Program

1010 Massachusetts Avenue 2nd Floor • Boston, Massachusetts 02118
TEL 617/534-2344 • FAX 617/534-2819

Sample Budgets

Administrative Cost Budget

ATTACHMENT C
RYAN WHITE PART A: ALN 93.914
Boston Public Health Commission
FY 2025
March 1, 2025 – February 28, 2026
AGENCY NAME
Medical Case Management

Core/Support Service Direct Cost	Personnel	Salary	FTE	Months	Annual
Program Director	B. Smith	$50,000	0.50	12	$25,000
Medical Case Manager	K. Jones	$45,000	1.00	12	$45,000
Medical Case Manager	J. Doe	$41,000	0.80	12	$32,800
		SUBTOTAL	2.3		$102,800
		FRINGE	30.00%		$30,840
					$133,640
Other Direct Care Cost					
Staff Training					$1,000
Staff Travel					$200
Program Supplies					$1,000
		SUBTOTAL			$2,200
		DIRECT CARE TOTAL			$135,840

Administrative Cost	Personnel	Salary	FTE	Months	Annual
Program Director	B. Smith	$50,000	0.15	12	$7,500
Program Rent (8% of total rent)					$6,084
		ADMIN COST TOTAL			$13,584
		DIRECT CARE TOTAL			$135,840
		ADMINISTRATIVE COST			$13,584
		SERVICE AWARD TOTAL			**$149,424**

Per Federal policy, funds may only be used to support services to those individuals with a documented HIV status. Funds may not be used to provide items or services for which payment already has been made or reasonably can be expected to be made, by third party payors, including Medicaid, Medicare, and/other State or local entitlement programs, prepaid health plans, or private insurance. Subrecipients are reminded that this is subject to an audit.

Indirect Rate Budget

ATTACHMENT C
RYAN WHITE PART A: ALN 93.914
Boston Public Health Commission
FY 2025
March 1, 2025 – February 28, 2026
AGENCY NAME
Psychosocial Support Services

Core/Support Service Direct Cost	Personnel	Salary	FTE	Months	Annual
Peer Support Coordinator	B. Smith	$32,000	0.50	12	$16,000
Peer Advocate	K. Jones	$28,000	0.20	12	$5,600
Peer Advocate	J. Doe	$28,000	0.30	12	$8,400
		SUBTOTAL	1.0		$30,000
		FRINGE	29.10%		$8,730
					$38,730
Other Direct Care Cost					
Staff Training					$1,000
Staff Travel					$200
Program Supplies					$1,000
		SUBTOTAL			$2,200
		DIRECT CARE TOTAL			$40,930

HHS Indirect Approved Rate	40%	Annual
Ryan White Indirect Rate Cap	10%	$4,093

DIRECT CARE TOTAL	$40,930
INDIRECT RATE CAP (10%)	$4,093
SERVICE AWARD TOTAL	**$45,023**

Per Federal policy, funds may only be used to support services to those individuals with a documented HIV status. Funds may not be used to provide items or services for which payment already has been made or reasonably can be expected to be made, by third party payors, including Medicaid, Medicare, and/other State or local entitlement programs, prepaid health plans, or private insurance. Subrecipients are reminded that this is subject to an audit.

Sample Invoicing

Administrative Cost Billing

BPHC Ryan White Part A Emergency Relief Funding

Monthly Invoice

Subrecipient Name:	**ENTER SUBRECIPIENT NAME HERE**

Federal Grant Number	H89HA00011
RW Part A ALN:	93.914

Pay To:	**WRITE COMPLETE SUBRECIPIENT NAME**
Address:	**ENTER AGENCY ADDRESS HERE**

Part A Service Category:	**ENTER FUNDED SERVICE HERE**
Activity Number:	**3556002**
BPHC PO Number:	**Enter new Fiscal Year PO**

Bill To:	Boston Public Health Commission Procure to Pay Office 1010 Massachusetts Avenue Boston, MA 02118

Invoice Submission Date:	**Enter submission Date**
Billing Period:	**Enter Billing Period**
Invoice Number: Cannot exceed 20 characters. Letters and numbers only. No special characters or spacing.	**RW25** [Insert MONTH & SERVICE abbrev.]

DIRECT CARE STAFF	*FTE*	*Budget (A)*	*Amount this Invoice (B)*	*Cumulative Billing (C)*	*Remaining Balance (D)*
Program Director	*0.00*	*$0*	*$0.00*	*$0.00*	*$0.00*
Medical Case Manager	*0.00*	*$0*	*$0.00*	*$0.00*	*$0.00*
Medical Case Manager	*0.00*	*$0*	*$0.00*	*$0.00*	*$0.00*
		$0	*$0.00*	*$0.00*	*$0.00*
Sub-total	*0.00*	*$0*	*$0.00*	*$0.00*	*$0.00*
Fringe	*30.00%*	*$0*	*$0.00*	*$0.00*	*$0.00*
Personnel Totals		***$0***	*$0.00*	*$0.00*	*$0.00*
OTHER DIRECT CARE COST					
Local Travel		*$0*	*$0.00*	*$0.00*	*$0.00*
Staff Training		*$0*	*$0.00*	*$0.00*	*$0.00*
Program Supplies		*$0*	*$0.00*	*$0.00*	*$0.00*
		$0	*$0.00*	*$0.00*	*$0.00*
Sub-total		*$0*	*$0.00*	*$0.00*	*$0.00*
DIRECT CARE TOTAL		*$0*	*$0.00*	*$0.00*	*$0.00*
ADMINISTRATIVE COST					
Program Director	*0.00*	*$0*	*$0.00*	*$0.00*	*$0.00*
Program Rent	*0%*	*$0*	*$0.00*	*$0.00*	*$0.00*
ADMINISTRATIVE COST TOTAL		*$0*	*$0.00*	*$0.00*	*$0.00*
TOTALS EXPENSE		***$0***	*$0.00*	*$0.00*	*$0.00*

Invoice Amount (No rounding. Use up to 2 decimal places) ***$0.00***

I hereby certify that the bills, receipts, and payroll documentation attached to this invoice are expenditures solely associated with the Ryan White Part A funding.

Prepared by:	*Authorized by:*
Contact Name:	**Name:**
Phone:	**Title:**
Email:	**Signature (blue ink):**

Indirect Rate Billing

BPHC Ryan White Part A Emergency Relief Funding

Monthly Invoice

Subrecipient Name:	**ENTER SUBRECIPIENT NAME HERE**

Federal Grant Number	H89HA00011
RW Part A ALN:	93.914

Pay To:	**WRITE COMPLETE SUBRECIPIENT NAME**
Address:	**ENTER AGENCY ADDRESS HERE**

Part A Service Category:	**ENTER FUNDED SERVICE HERE**
Activity Number:	**3556002**
BPHC PO Number:	**Enter new Fiscal Year PO**

Bill To:	Boston Public Health Commission Procure to Pay Office 1010 Massachusetts Avenue Boston, MA 02118

Invoice Submission Date:	**Enter submission Date**
Billing Period:	**Enter Billing Period**
Invoice Number: Cannot exceed 20 characters. Letters and numbers only. No special characters or spacing.	**RW25** [Insert MONTH & SERVICE abbrev.]

DIRECT CARE STAFF	***FTE***	***Budget (A)***	***Amount this Invoice (B)***	***Cumulative Billing (C)***	***Remaining Balance (D)***
Program Director	*0.00*	*$0*	*$0.00*	*$0.00*	*$0.00*
Medical Case Manager	*0.00*	*$0*	*$0.00*	*$0.00*	*$0.00*
Medical Case Manager	*0.00*	*$0*	*$0.00*	*$0.00*	*$0.00*
		$0	*$0.00*	*$0.00*	*$0.00*
Sub-total	*0.00*	*$0*	*$0.00*	*$0.00*	*$0.00*
Fringe	*30.00%*	*$0*	*$0.00*	*$0.00*	*$0.00*
Personnel Totals		***$0***	*$0.00*	*$0.00*	*$0.00*
OTHER DIRECT CARE COST					
Local Travel		*$0*	*$0.00*	*$0.00*	*$0.00*
Staff Training		*$0*	*$0.00*	*$0.00*	*$0.00*
Program Supplies		*$0*	*$0.00*	*$0.00*	*$0.00*
		$0	*$0.00*	*$0.00*	*$0.00*
Sub-total		*$0*	*$0.00*	*$0.00*	*$0.00*
DIRECT CARE TOTAL		*$0*	*$0.00*	*$0.00*	*$0.00*
HHS INDIRECT APPROVED RATE					
Ryan White Indirect Rate Cap	*10%*	*$0*	*$0.00*	*$0.00*	*$0.00*
HHS INDIRECT APPROVED RATE COST TOTAL (10% Cap)		*$0*	*$0.00*	*$0.00*	*$0.00*
TOTALS EXPENSE		***$0***	*$0.00*	*$0.00*	*$0.00*

Invoice Amount (No rounding. Use up to 2 decimal places) ***$0.00***

I hereby certify that the bills, receipts, and payroll documentation attached to this invoice are expenditures solely associated with the Ryan White Part A funding.

Prepared by:	***Authorized by:***
Contact Name:	**Name:**
Phone:	**Title:**
Email:	**Signature (blue ink):**

Resources

Please see the following websites that will aid in program management and development.

Local Resources

1) Boston Public Health Commission Ryan White Services: The Boston Public Health Commission Ryan White Services programs are integral to the distribution of Ryan White Part A funding within the Boston EMA, and the success of our funded agencies to promote health and enhance the quality of life for PLWHA. Included on the website are provider forms, quality management reports and resources, and pertinent links for HRSA-related information.
2) Massachusetts Department of Public Health Office of HIV/AIDS: The Massachusetts Department of Public Health Office of HIV/AIDS provides a variety of services throughout the Commonwealth of Massachusetts. Currently, services range from prevention and education to HIV counseling and testing, client services, health, and support services.
3) The New England AIDS Education and Training Center (NEAETC): Provides HIV/AIDS education, consultation, technical assistance, and resource materials to healthcare professionals throughout Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

Federal Resources

1) Health Resources and Services Administration (HRSA): HRSA administers programs that improve the nation's health by expanding access to comprehensive, quality health care for all Americans. HRSA is the federal grantee of Ryan White Act funding. The National Monitoring Standards for Part A are located here. Please see the Policy Clarification Notes for more information.
2) Target HIV: The TargetHIV website is the one-stop shop for technical assistance (TA) and training resources for HRSA's Ryan White HIV/AIDS Program (RWHAP), the federal program that funds local and state agencies to deliver HIV care for people living with HIV who are uninsured or underinsured. Resources include webinars, tools, training materials, manuals, and guidelines that focus on RWHAP service delivery and agency operations.
3) Centers of Disease Control Divisions of HIV/AIDS Prevention (CDC): The CDC Division of HIV/AIDS Prevention's mission is to prevent HIV infection and reduce the incidence of HIV-related illness and death in collaboration with the community, state, national, and international partners. *Links include* Basic Science, Surveillance, Prevention Research, Vaccine Research, Prevention Tools, Treatment, Funding, Testing, Evaluation, Software, Training, STD Prevention, and TB Prevention.
4) Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA is improving the quality and availability of prevention, treatment, and rehabilitative services to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness.

5) Grants.gov: A tool created by the Department for Health and Human Services (DHHS) and the Office of Grants Management (OGM) for finding and exchanging information about federal grant programs. Grants.gov serves the general public, the grantee community, and grant-makers.

Policy Clarification Notices

The Ryan White HIV/AIDS Program legislation was first enacted in 1990 as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. It has been amended and reauthorized four times: in 1996, 2000, 2006, and 2009. The legislation, the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009), delineates the statutory requirements of the program.

HRSA develops policies that implement the legislation, providing guidance to recipients in understanding and implementing legislative requirements. These policies are listed below, followed by program letters, which provide additional guidance for recipients.

- 21-02 Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program (Revised 3/13/25)
    - Dear Colleague Letter for PCN 21-02
- 21-01 Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement (Revised 10/01/24)
    - Dear Colleague Letter for PN 21-01
- 18-02 The Use of Ryan White HIV/AIDS Program Funds for Core Medical Services and Support Services for People Living with HIV Who Are Incarcerated and Justice Involved
- 18-01 Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance
- 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds (Revised 10/22/18)
    - Housing Services Frequently Asked Questions for Policy Clarification Notice 16-02
    - Standalone Dental Insurance Frequently Asked Questions for Policy Clarification Notice 16-02
    - Frequently Asked Questions for Policy Clarification Notice 16-02
- 16-01 Clarification of the Ryan White HIV/AIDS Program (RWHAP) Policy on Services Provided to Veterans
- 15-04 Utilization and Reporting of Pharmaceutical Rebates (Revised 1/11/19)
    - Frequently Asked Questions for Policy Clarification Notices 15-03 and 15-04
- 15-03 Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income

- 15-02 Clinical Quality Management Policy Clarification Notice (Revised 9/01/20)
    - Frequently Asked Questions for Policy Clarification Notice 15-02
- 15-01 Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Part A, B, C, and D (Revised 09/01/20)
    - Frequently Asked Questions for Policy Clarification Notice 15-01
- 14-01 Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Advance Premium Tax Credits Under the Affordable Care Act
    - Frequently Asked Questions for Policy Clarification Notice 14-01
    - Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Advanced Premium Tax Credits Under the Affordable Care Act Federal Register (07/14/2014)
- 13-07: Uniform Standard for Waiver of Core Medical Services Requirement for Grantees Under Parts, A, B, and C Replaced by 21-01 effective 10/1/2021.
    - Sample Letters for Requesting a Waiver of the Core Medical Services Requirement in the Ryan White HIV/AIDS Program
    - October 25, 2013 Federal Register Notice on the Core Medical Services Waiver Requirements
    - May 24, 2013 Federal Register Notice on: Ryan White HIV/AIDS Program Core Medical Services Waiver; Application Requirement
- 13-04 Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program
- 13-03 Ryan White HIV/AIDS Program Client Eligibility Determinations: Considerations Post-Implementation of the Affordable Care Act
- 13-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertifications Requirements Replaced by 21-02 effective 10/19/2021.
- 13-01 Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by Ryan White HIV/AIDS Program
- 12-02 Part A and Part B Unobligated Balances and Carryover
- 11-03 Residence of Planning Council Members and Consortia Members
- 11-02 Clarification of Legislative Language Regarding Contracting with For Profit Entities
- 07-03 Use of Ryan White HIV/AIDS Program Part B ADAP Funds for Access, Adherence, and Monitoring Services
- 07-02 Use of Ryan White HIV/AIDS Program Funds for HIV Diagnostics and Laboratory Tests Policy

- 07-01 Use of Funds for American Indians and Alaska Natives and Indian Health Service Programs