COUNTY OF SAN MATEO
Inter-Departmental Correspondence
Health System

DATE: February 3, 2012
BOARD MEETING DATE: February 28, 2012
SPECIAL NOTICE/HEARING: None
VOTE REQUIRED: Majority

TO: Honorable Board of Supervisors

FROM: Jean S. Fraser, Chief, Health System
John Conley, Director, Public Health

SUBJECT: Amendment A01 to Agreement with the California Department of Public Health

RECOMMENDATION:
Adopt a Resolution authorizing the President of the Board to execute Amendment A01 to Agreement 10-95289 with the California Department of Public Health for the term of July 1, 2010 through June 30, 2013, decreasing the amount by $39,700 to $1,736,534.

BACKGROUND:
Since 1993 the California Department of Public Health (CDPH) has been providing funding to the San Mateo Public Health STD/HIV Program (SMSH) to provide HIV/AIDS outpatient/ambulatory medical care, prevention and surveillance services. Funds for these services are awarded to SMSH under one Master Grant Agreement plus one Memorandum of Understanding (MOU) for each program funded.

On January 11, 2011, your Board approved Agreement No. 10-95289 with CDPH for $1,776,234, to fund the above-mentioned services for the term July 1, 2010 through June 30, 2013.

DISCUSSION:
Amendment A01 reduces funding by $39,700 for FY 2011-12 and FY 2012-2013. Funds for the HIV Care Program have been decreased by $24,822 and funding for the Surveillance Program has been reduced by $14,878. Contract deliverables have been adjusted to accommodate the changes in funding.

County Counsel has reviewed and approved the Agreement and Resolution as to form.

Approval of this Agreement contributes to the Shared Vision 2025 outcome of a Healthy Community by providing HIV/AIDS ambulatory/outpatient medical care, prevention and

surveillance services to individuals affected by HIV/AIDS. It is anticipated that the viral load of 77% of clients receiving services will decrease or remain undetectable as a result of the medical and psycho-social services received.

Performance Measure:

Measure	FY 2010-11 Actual*	FY 2011-12 Projected
Percentage of clients whose viral load will decrease or remain undetectable as a result of the medical care and psycho-social services received.	76%	77%

* Actual percentage for this fiscal year exceeded projections.

FISCAL IMPACT:

The term of the Agreement remains July 1, 2010 through June 30, 2013. The amount of the original Agreement was $1,776,234. Amendment A01 decreases funding by $39,700, for a new total amount of $1,736,534. A reduction in funding in the amount of $19,850 is included in the Public Health FY 2011-12 Adopted Budget. A funding decrease in the amount of $19,850 will be included in the Public Health FY 2012-13 Recommended Budget. There is no Net County Cost.

RESOLUTION NO. _____

BOARD OF SUPERVISORS, COUNTY OF SAN MATEO, STATE OF CALIFORNIA

*** * * * * ***

RESOLUTION AUTHORIZING THE PRESIDENT OF THE BOARD TO EXECUTE AMENDMENT A01 TO AGREEMENT 10-95289 WITH THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH FOR THE TERM OF JULY 1, 2010 THROUGH JUNE 30, 2013, DECREASING THE AMOUNT BY $39,700 TO $1,736,534

RESOLVED, by the Board of Supervisors of the County of San Mateo, State of California, that

WHEREAS, there has been presented to this Board of Supervisors for its consideration and acceptance Amendment A01 to an Agreement with the California Department of Public Health, reference to which is hereby made for further particulars, whereby the County shall provide HIV/AIDS outpatient/ambulatory medical care, prevention and surveillance services; and

WHEREAS, the term of the Agreement remains July 1, 2010 through June 30, 2013, and the contract amount for the period of July 1, 2011 through June 30, 2013 has been reduced by $39,700, decreasing the maximum obligation from to $1,736,534; and

WHEREAS, this Board has been presented with the Amendment to the Agreement and has examined and approved it as to both form and content and desires to enter into the Amendment.

NOW, THEREFORE, IT IS HEREBY DETERMINED AND ORDERED that the President of this Board of Supervisors be and is hereby authorized and directed to execute said Amendment for and on behalf of the County of San Mateo, and the Clerk of the Board shall attest the President’s signature thereto.

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD 213A_CDPH (9/09)

☒ Check here if additional pages are added: 1 Page(s)

Agreement Number	Amendment Number
10-95289	A01
Registration Number:	

1. This Agreement is entered into between the State Agency and Contractor named below:

State Agency's Name (Also known as CDPH or the State)
California Department of Public Health

Contractor's Name (Also referred to as Contractor)
County of San Mateo

2. The term of this Agreement is: July 1, 2010 through June 30, 2013

3. The maximum amount of this Agreement after this amendment is: **$** 1,736,534 One Million, Seven Hundred Thirty Six Thousand, Five Hundred Thirty Four Dollars.

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. **Amendment effective date:** July 1, 2011

II. **Purpose of amendment:** This amendment decreases the funding level for years 2 and 3 of the contract term due to the revised state allocation formula.

III. Certain changes made in this amendment are shown as: Text additions are displayed in bold and underline. Text deletions are displayed as strike through text (i.e., Strike).

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

Contractor's Name *(If other than an individual, state whether a corporation, partnership, etc.)*
County of San Mateo

By *(Authorized Signature)* ✍ | Date Signed *(Do not type)*

Printed Name and Title of Person Signing
Adrienne J. Tissier, President, Board of Supervisors

Address
C/O Matt Geltmaker, STD/HIV Program Director, San Mateo County Health System, 225 - 37th Avenue, San Mateo, CA 94403

STATE OF CALIFORNIA

Agency Name
California Department of Public Health

By *(Authorized Signature)* ✍ | Date Signed *(Do not type)*

Printed Name and Title of Person Signing
Sandra Winters, Chief, Contracts and Purchasing Services Section

Address
1501 Capitol Avenue, Suite 71.5178, MS 1802, P.O. Box 997377, Sacramento, CA 95899-7377

CALIFORNIA Department of General Services Use Only

☒ Exempt per: Budget Act of 2011, Chapter 33

IV. Paragraph 3 (maximum amount payable) on the face of the original STD 213 is decreased by $39,700 and is amended to read: ~~$1,776,234 (One Million, Seven Hundred Seventy Six Thousand, Two Hundred Thirty Four Dollars.)~~ **$1,736,534 (One Million, Seven Hundred Thirty Six Thousand, Five Hundred Thirty Four Dollars.)**

V. Provision 4 (Amounts Payable) of Exhibit B – Budget Detail and Payment Provisions is amended to read as follows:

4. Amounts Payable

A. The amounts payable under this agreement shall not exceed:

1) $607,796 for the budget period of 07/01/10 through 06/30/11.
2) $~~584,219~~ **564,369** for the budget period of 07/01/11 through 06/30/12.
3) $~~584,219~~ **564,369** for the budget period of 07/01/12 through 06/30/13.

B. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

VI. All other terms and conditions shall remain the same.

Memorandum of Understanding (MOU)
Amendment 1
HIV Care Program

In that certain agreement made and entered into July 1, 2010 between the California Department of Public Health/Office of AIDS and the County of San Mateo.

1. Provision 2 (MAXIMUM AMOUNT PAYABLE) is amendment to read as follows:

   The maximum amount payable by the STATE to the CONTRACTOR under this MOU shall not exceed the following:

   A. $307,870 for the budget period of July 1, 2010 to June 30, 2011.
   B. ~~$307,870~~ **295,459** for the budget period of July 1, 2011 to June 30, 2012.
   C. ~~$307,870~~ **295,459** for the budget period of July 1, 2012 to June 30, 2013.
   D. ~~$923,610~~ **898,788** for the entire MOU term.

2. Provision 3 (MOU EXHIBITS) is amended to add **Exhibit A-4, entitled "Scope of Work" Year 2 consisting of 21 pages; Exhibit A-5, entitled "Scope of Work" Year 3 consisting of 21 pages**. All further references to Exhibits A, A-1, and A-2, in the body of this agreement or any attachments thereto shall be deemed to read Exhibit A-3, entitled "Scope of Work" Year 1; Exhibit A-4, entitled "Scope of Work" Year 2; and Exhibit A-5, entitled "Scope of Work" Year 3.

   Provision 3 (MOU EXHIBITS) is further amended to add **Exhibit B-2 A1, entitled "Budget" Year 2 consisting of one page to be replaced in its entirety; Exhibit B-3 A1, entitled "Budget" Year 3 consisting of one page to be replaced in its entirety**. All further references to Exhibits B, entitled "Budget" Years 1, 2, and 3 in the body of this agreement or any attachments thereto shall be deemed to read Exhibit B-1, entitled "Budget" Year 1; Exhibit B-2 A1, entitled "Budget" Year 2; and Exhibit B-3 A1, entitled "Budget" Year 3.

3. The effective date of this amendment shall be July 1, 2011.

4. All other terms and conditions shall remain the same.

Exhibit B-2, A1
BUDGET
Year 2
July 1, 2011 through June 30, 2012

	HCP Budget	MAI Budget	Total MOU Budget
A. PERSONNEL	$195,872	$24,258	$220,130
B. OPERATING EXPENSES	$7,043	$1,742	$8,785
C. CAPITAL EXPENDITURES	$0	$0	$0
D. OTHER COSTS	$66,544	$0	$66,544
E. INDIRECT COSTS	$0	$0	$0
TOTALS	**$269,459**	**$26,000**	**$295,459**

Exhibit B-3, A1
BUDGET
Year 3
July 1, 2012 through June 30, 2013

	HCP Budget	MAI Budget	Total MOU Budget
A. PERSONNEL	$195,872	$24,258	$220,130
B. OPERATING EXPENSES	$7,043	$1,742	$8,785
C. CAPITAL EXPENDITURES	$0	$0	$0
D. OTHER COSTS	$66,544	$0	$66,544
E. INDIRECT COSTS	$0	$0	$0
TOTALS	**$269,459**	**$26,000**	**$295,459**

HIV Care Program (HCP)

Exhibit C-2
HCP Summary Tracking

County of XXX
10-XXXXX A01

2011-12 HCP Summary Tracking - Contractor's Name

Service Period:
Contractor's Invoicing Contact(s):

Contract No.

Counties:
OA HCP Invoicing Contact: **Ivo Klemes (916) 449-5986**

Section 1 - Client Service Costs									
Services Provided by HRSA Category	Budgeted Amount	Budget Revision #1	Allocation after Revision	Expenditures to Date	Balances	1st Quarter 2011	2nd Quarter 2011	3rd Quarter 2012	4th Quarter 2012
			$ -	$ -	$ -				
			$ -	$ -	$ -				
			$ -	$ -	$ -				
			$ -	$ -	$ -				
			$ -	$ -	$ -				
			$ -	$ -	$ -				
			$ -	$ -	$ -				
			$ -	$ -	$ -				
			$ -	$ -	$ -				
Subtotal Client Service Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Section 2 - Contractor's Needs Assessment Costs (Can't Exceed 5% of Total Allocation)									
Subtotal Contractor's Needs Assessment Costs			**$ -**	**$ -**	**$ -**				
Section 3 - Contractor's Administration Costs (Can't Exceed 10% of total Allocation)									
Personnel			$ -	$ -	$ -				
Operating Expenses			$ -	$ -	$ -				
Capital Expenses			$ -	$ -	$ -				
Indirect Costs (no more than 15% of Personnel)			$ -	$ -	$ -				
Subtotal Contractor's Administration Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Section 4 - Contractor's Client Service Administration Costs (Can't Exceed 10% of Client Service Allocation)									
Personnel			$ -	$ -	$ -				
Operating Expenses			$ -	$ -	$ -				
Capital Expenses			$ -	$ -	$ -				
Indirect Costs (no more than 15% of Personnel)			$ -	$ -	$ -				
Subtotal Contractor's Administration Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Section 5 - Client Service Providers' Administration Costs (Can't Exceed 10% of Each Client Service Provider's Total Allocation)									
Personnel			$ -	$ -	$ -				
Operating Expenses			$ -	$ -	$ -				
Capital Expenses			$ -	$ -	$ -				
Indirect Costs (no more than 15% of Personnel)			$ -	$ -	$ -				
Subtotal Sub. Client Service Admin. Costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Section 6 - Totals									
TOTALS	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Section 7 - Five Line Invoice Tracking	Budgeted Amount	Budget Revision #1	Allocation after Revision	Expenditures to Date	Balance	1st Quarter 2011	2nd Quarter 2011	3rd Quarter 2012	4th Quarter 2012
Date Invoice Received in the Office/Budget Revision Approval Date									
Personnel			$ -	$ -	$ -				
Operating Expenses			$ -	$ -	$ -				
Capital Expenses			$ -	$ -	$ -				
Other Costs			$ -	$ -	$ -				
Indirect Costs			$ -	$ -	$ -				
TOTALS	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Minority AIDS Initiative Program (MAI)

Exhibit D-2
MAI Summary Tracking

County of XXX
10-XXXXX A01

2011-12 MAI Summary Tracking - Contractor's Name

Service Period:
Contractor's Invoicing Contact(s):

Contract No.

Counties:
OA MAI Invoicing Contact: **Ivo Klemes (916) 449-5986**

		Budget	Revision #1	Rev. Allocation	Exp. to Date	**Balances**	July-Sept.	Oct.-Dec.	Jan.-March	April-June
Services	Outreach			$ -	$ -	**$ -**				
Services	Treatment Ed.			$ -	$ -	**$ -**				
Administration Contractor	Personnel			$ -	$ -	**$ -**				
	Operating			$ -	$ -	**$ -**				
	Indirect			$ -	$ -	**$ -**				
	Subtotal	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
Administration Client Services Contractor	Personnel			$ -	$ -	**$ -**				
	Operating			$ -	$ -	**$ -**				
	Indirect			$ -	$ -	**$ -**				
	Subtotal	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
Administration Client Services Subcontractor	Personnel			$ -	$ -	**$ -**				
	Operating			$ -	$ -	**$ -**				
	Indirect			$ -	$ -	**$ -**				
	Subtotal	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -
Total		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Date When Revision was Approved:		Date Invoice Received in the Office:				

Five Line Invoice Tracking	Budget	Revision #1	Rev. Allocation	Exp. to Date	**Balances**	July-Sept.	Oct.-Dec.	Jan.-March	April-June
Personnel			$ -	$ -	**$ -**				
Operating Expenses			$ -	$ -	**$ -**				
Capital Expenses			$ -	$ -	**$ -**				
Other Costs			$ -	$ -	**$ -**				
Indirect Costs			$ -	$ -	**$ -**				
Total	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Memorandum of Understanding (MOU)
Amendment 1
HIV/AIDS Surveillance Program

In that certain agreement made and entered into July 1, 2010 between the California Department of Public Health/Office of AIDS and the County of San Mateo.

1. Provision 2 (MAXIMUM AMOUNT PAYABLE) is amendment to read as follows:

   The maximum amount payable by the STATE to the CONTRACTOR under this MOU shall not exceed the following:

   A. $112,706 for the budget period of July 1, 2010 to June 30, 2011.
   B. ~~$112,706~~ **105,267** for the budget period of July 1, 2011 to June 30, 2012.
   C. ~~$112,706~~ **105,267** for the budget period of July 1, 2012 to June 30, 2013.
   D. ~~$338,118~~ **323,240** for the entire MOU term.

2. Provision 3 (MOU EXHIBITS) is amended to add **Exhibit A-2, entitled "Scope of Work" Year 2 consisting of 6 pages; Exhibit A-3, entitled "Scope of Work" Year 3 consisting of 6 pages**. All further references to Exhibit A, entitled "Scope of Work" in the body of this agreement or any attachments thereto shall be deemed to read Exhibit A-1, entitled "Scope of Work" Year 1; Exhibit A-2, entitled "Scope of Work" Year 2; and Exhibit A-3, entitled "Scope of Work" Year 3.

   Provision 3 (MOU EXHIBITS) is further amended to add **Exhibit B-2 A1, entitled "Budget" Year 2 consisting of one page; Exhibit B-3 A1, entitled "Budget" Year 3 consisting of one page**. All further references to Exhibits B, entitled "Budget" Years 1, 2, and 3 in the body of this agreement or any attachments thereto shall be deemed to read Exhibit B-1, entitled "Budget" Year 1; Exhibit B-2 A1, entitled "Budget" Year 2; and Exhibit B-3 A1, entitled "Budget" Year 3.

3. The effective date of this amendment shall be July 1, 2011.

4. All other terms and conditions shall remain the same.

Exhibit B-2, A1
Budget
Year 2

July 1, 2011 to June 30, 2012

	Original Budget	This Amendment	Amended Total
A. PERSONNEL	$112,706	**($7,439)**	**$105,267**
B. OPERATING EXPENSES	$0	$0	$0
C. CAPITAL EXPENDITURES	$0	$0	$0
D. OTHER COSTS	$0	$0	$0
E. INDIRECT COSTS	$0	$0	$0
TOTAL BUDGET	**$112,706**	**($7,439)**	**$105,267**

Exhibit B-3, A1
Budget
Year 3

July 1, 2012 to June 30, 2013

	Original Budget	This Amendment	Amended Total
A. PERSONNEL	$112,706	**($7,439)**	**$105,267**
B. OPERATING EXPENSES	$0	$0	$0
C. CAPITAL EXPENDITURES	$0	$0	$0
D. OTHER COSTS	$0	$0	$0
E. INDIRECT COSTS	$0	$0	$0
TOTAL BUDGET	**$112,706**	**($7,439)**	**$105,267**

Exhibit A-4
HIV Care Program and Minority AIDS Initiative
Scope of Work, Year 2

I. Introduction

1. Mission Statement

The goals of the California Department of Public Health, Office of AIDS (CDPH/OA) are: (1) to minimize new HIV infections and (2) to maximum the number of people with HIV infection who access appropriate care, treatment, support, and prevention services. The services required by the HIV Care Program (HCP) and Minority AIDS Initiative (MAI) Scopes of Work (SOWs) in this Memorandum of Understanding are consistent with, and are designed to support, these goals.

2. Service Overview

CDPH/OA utilizes federal Health Resources Services Administration (HRSA) funds to provide support for HIV/AIDS services in local areas. Federal HRSA funds include Part B and Minority AIDS Initiative funding. HIV care services are funded using a Single Allocation Model to consolidate HRSA program funds into a single contract in each local health jurisdiction or service area.

Through this single contract, the Contractor agrees to administer (A) **HCP** and, if applicable, *(*B) **MAI Outreach and Treatment Education Services**.

A. The Contractor agrees to administer HCP and to ensure the provision of the HIV care services as described in this SOW. The Contractor may provide direct client services exclusively or subcontract all or part of the client services. The Contractor ensures that, if all or parts of the client services are subcontracted to other client service providers, all services provided by the subcontracted agency will be in accordance with HCP

B. If funded, the Contractor agrees to administer the MAI outreach and treatment education services focused on providing access to, and engagement in, medical care for HIV-positive persons of color, including access to AIDS Drug Assistance Program (ADAP), Medi-Cal, or other appropriate program

II. HIV Care Program

1. HCP Services

The HIV care services to be provided under HCP are HRSA-defined service categories. For a listing of HRSA service category definitions, and the specific services included in each category, please refer to the HRSA website at www.hab.hrsa.gov. Additional information can be found in the *HCP and Budget Guidelines.*

CDPH/OA will not require local utilization of HRSA's "75 percent (Core services) / 25 percent (Support services)" requirement for prioritization of services.

Exhibit A-4
HIV Care Program and Minority AIDS Initiative
Scope of Work, Year 2

HCP is a two-tiered approach to service prioritization and delivery and utilizes the HRSA-defined service categories, both the Core and Support service categories.

HCP prioritizes service provisions as follows:

Tier One: *Outpatient/Ambulatory Medical Care,* as defined by HRSA. Services include, but are not limited to, primary medical care, laboratory testing, medical history taking, health screening, and prescribing and managing medications. Contractors must ensure that Tier One medical services are provided for all population groups in their geographic region via all HIV/AIDS or other funding sources before allocating HCP funds to Tier Two services.

Tier Two: HRSA-defined Core and Support service categories that (1) assist with access to Tier One care, (2) support maintenance in Tier One care, and (3) reduce the risk of treatment failure and/or HIV transmission. HCP funds may be allocated for any Tier Two service only after Contractors have ensured Tier One services are adequately provided in their geographic region via all HIV/AIDS or other funding sources.

The following HRSA service categories are included in Tier Two of HCP:

- *Mental Health Services*
- *Medical Case Management Svcs (includes Treatment Adherence)*
- *Case Management (Non-Medical)*
- *Oral Health Care*
- *AIDS Pharmaceutical Assistance*
- *Substance Abuse Services - Outpatient and Residential*
- *Health Education/Risk Reduction*
- *Home Health Care*
- *Hospice Services*
- *Outreach Services*
- *Emergency Financial Assistance*
- *Food Bank/Home-Delivered Meals*
- *Housing Services*
- *Legal Services*
- *Treatment Adherence Counseling*
- *Health Insurance Premium and Cost Sharing Assistance*
- *Home- and Community-Based Health Services*
- *Linguistic Services*
- *Medical Transportation Services*
- *Psychosocial Support Services*
- *Medical Nutrition Therapy*
- *Early Intervention Services*
- *Referral for Health Care/Supportive Services*
- *Rehabilitation Services*
- *Respite Care*
- *Child Care Services*

A. The Contractor shall:

1. Provide comprehensive, ongoing medical services to individuals with HIV/AIDS. Services must be based on the HRSA service category, *Outpatient/Ambulatory Medical Care* or, if these services are not funded by HCP under Tier One, the Contractor must demonstrate and document the availability of primary medical care for HIV-infected persons within each population group in the service area.

Exhibit A-4
HIV Care Program and Minority AIDS Initiative
Scope of Work, Year 2

2. Provide Tier Two HRSA Core and Support services as necessary, and as funds permit, to ensure access to Tier One care, maintenance in Tier One care, and reduce the risk of treatment failure or HIV transmission.

3. Develop and implement a system of service delivery that offers comprehensive, ongoing health and support services to individuals with HIV/AIDS, that actively seeks individuals who know their HIV status but are not accessing services, that reaches out to people who are HIV positive but unaware of their HIV status, and that is coordinated and integrated with other service delivery systems as appropriate.

4. Advisory and/or focus groups will meet at least **annually** to provide input to the Contractor on issues such as needs assessment, service delivery plans, and comprehensive planning. The Contractor shall maintain minutes and/or documentation of the advisory or focus group meetings.

   The advisory and/or focus group, should be made up of representatives from state, federal, and local programs that provide health services and education and prevention services; non-profit and for-profit community-based agencies; staff from other key points of entry into medical care, who either provide services to individuals with HIV/AIDS, or who may have contact with HIV positive individuals who are not in care or not aware of their HIV status; individuals with HIV, and their advocates, etc. The advisory group provides information to the Contractor regarding health services delivery and the needs of individuals with HIV/AIDS living within the community.

5. Ensure the protection of the client's privacy and confidentiality at all times. In addition, federal law requires that individuals have a right of access, to inspect, and obtain a copy of their protected health information (PHI) in a designated record set, for as long as the health information is maintained by a CDPH health plan, CDPH providers, or business associates. There are limited exceptions to an individual's right of access PHI (45 C.F. R. s 164.524).

6. Ensure that any subcontracted agencies have the organizational and administrative capabilities to support the program services and activities. The Contractor is responsible for quality assurance and utilization review activities for subcontracted HIV care services.

7. Ensure that any subcontracted agencies have appropriate facilities and resources, including an adequate physical plant and appropriate supplies and equipment available for the provision of services and practical support functions.

8. Develop and maintain working relationships, and coordinate an integrated system of service delivery, with entities who provide key points of entry

into medical care, including but not limited to emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, California Department of Corrections and Rehabilitation, Transitional Case Management Program (TCMP) for incarcerated populations, sexually transmitted disease (STD) clinics, HIV counseling and testing sites, mental health programs, homeless shelters, health care points of entry specified by the State, federally qualified health centers, migrant health centers, community health centers, health services for the homeless, family planning grantees, comprehensive hemophilia diagnostic and treatment centers, and non-profit and for profit private entities that provide comprehensive primary care services to populations at risk for HIV. The coordinated, integrated system of care must be informed by HIV epidemiological data and other data sources and should include leveraged resources. The Contractor shall keep documentation of these working relationships.

9. Ensure that case management services that link available community support services to appropriate specialized medical services shall be provided for individuals residing in rural areas as appropriate.

10. Ensure HIV care services will be provided in a setting that is accessible to low-income individuals with HIV disease. Facilities must also be accessible for hearing-, vision-, and mobility-impaired persons in accordance with the federal Americans with Disabilities Act (ADA).

11. Provide targeted prevention coordinated with all state and federal programs to low-income individuals with HIV disease and to inform such individuals of the services available under Ryan White Part B.

12. To the maximum extent practical, ensure that HIV-related health care and support services delivered pursuant to a program established with assistance provided under Ryan White Part B will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual with HIV disease.

13. Ensure that services provided to women, infants, children, and youth are tracked and reported (see Data Collection, subheading F).

14. Ensure that services provided under this contract are in accordance with the program policy guidance issued by Division of Service Systems (DSS), HIV/AIDS Bureau (HAB) (see www.hab.hrsa.gov), CDPH/OA's *HCP and Budget Guidelines.*

15. Ensure that the Ryan White HIV/AIDS Program funds do not comprise more than sixty percent (60%) of any subcontracted agency's total budget. Ryan White HIV/AIDS Program funds are intended to provide

Exhibit A-4
HIV Care Program and Minority AIDS Initiative
Scope of Work, Year 2

additional funding to those areas negatively affected by HIV disease and cannot be used to supplant local HIV-related budgets.

16. Ensure that clients are eligible for Ryan White services in accordance with the program policy guidance issued by DSS, HAB (see www.hab.hrsa.gov). Screening and reassessment of client eligibility must be completed and documented every 6 months to determine continued eligibility for Ryan White services.

    Ensure that eligibility policies do not deem a Veteran living with HIV ineligible for Ryan White services due to eligibility for Department of Veterans Affairs (VA) health care benefits. Ensure policies and procedures classifying veterans receiving VA health benefits as uninsured, thus exempting these Veterans from the "Payer of Last Resort" requirement per Veterans Policy 07-07, Policy 04-01, and Parham Letter 08/04 (see www.hab.hrsa.gov).

17. Ensure that no more than ten percent (10%) of the allocation is used for non-direct service functions such as:

    a. Routine contract administration and monitoring activities, including the preparation of applications for these funds, the receipt and disbursal of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine programmatic and financial reports, and compliance with contract conditions and audit requirements;

    b. All activities associated with the Contractor's subcontract award procedures, including the development of request for proposals, contract proposal review activities, negotiation and awarding of subcontracts, grievance process, monitoring of subcontracts through telephone consultation or onsite visits, reporting on subcontracts and funding reallocation activities.

18. In addition, ensure that no more than ten percent (10%) of the allocation is used for all subcontracted agencies' non-direct service (administrative) functions without prior written consent from OA.

19. Conduct assessment of HIV/AIDS service needs for the geographic service area at least once every three years. Review the assessment annually and, if needed, update it. Ensure that no more than five percent (5%) of the allocation is utilized to plan, conduct, and evaluate the needs assessment process. Needs assessment activities may not be billed to CDPH/OA more than once during a three year contract period.

20. Ensure that client service providers who provide Medi-Cal reimbursable services are certified as providers for purposes of Medi-Cal billing (see

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www.medi-cal.ca.gov) and have the ability to bill other third-party payers for covered services.

21. Ensure that funds are payer of last resort by ensuring that client service providers bill all other third-party payers, including Medi-Cal, before invoicing HCP.

22. Funded service providers should integrate, and work collaboratively, with other such services and coordinate with other available programs (including Medicaid), to ensure continuity of care and prevention of services of individuals with HIV is enhanced.

23. Ensure documentation of written referral relationships with entities considered key points of access to healthcare systems for the purpose of facilitating early intervention services for individuals diagnosed as being HIV positive.

    a. Work with consortia, service providers, and individuals with HIV/AIDS to identify key points of entry.
    b. Monitor the use of referral and linkage agreements by funded service providers.

24. Ensure funds are not used on prohibited activities (see www.hrsa.hab.gov) and CDPH/OA's HCP and Budget Guidelines.

25. Prohibit employees from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.

    a. Documentation is required by the Compliance Plan or employee conduct standards that prohibit employees from receiving payments in kind or cash from suppliers and contractors of goods or services.

26. Ensure that funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service:

    a. Under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

    b. By an entity that provides health services on a prepaid basis.

27. Ensure that funds are not used to:

    a. Make cash payment to intended recipients of services;

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b. Develop, promote, or advertise about HIV services that target the general public.

c. Generate broad scope awareness activities about HIV services that target the general public.

d. Pay costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools), or to pay any amount expended by a State under Title XIX of the Social Security Act.

e. Pay for any item or service that can reasonably be expected to be paid under any State Compensation program, insurance policy, or any Federal or State Health Benefits Program (except for programs related to Indian Health Service);

f. Pay for any item or service that can paid by an entity that provides health services on a prepaid basis;

g. For the development of materials, designed to promote or encourage, directly or indirectly, intravenous drug use or sexual activity;

h. Purchase or improve (other than minor remodeling) any building or other facility; or

i. Pay for automobile parts, repairs, or maintenance, pet care or supplies, funeral expenses, etc. (see www.hab.hrsa.gov).

28. Ensure that all approved subcontracted agency invoices are paid within 45 days of receipt.

29. Ensure that no funds are carried over into subsequent contract years.

30. Ensure compliance with the federal HRSA Ryan White Program, CDPH/OA's *HCP and Budget Guidelines,* CDPH/OA Policy Letters, Management Memoranda, AIDS Regional Information and Evaluation System (ARIES) Policy Notices, and other program guidelines issued by CDPH/OA.

31. Administer Ryan White Part B funds appropriately, maintain records and invoices using standard accounting practices, coordinate federal and state data reporting, and arrange for fiscal audits.

32. Annually evaluate the cost-effectiveness of the mechanisms used to deliver comprehensive care.

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33. When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, the Contractor shall clearly state the percentage of the total costs of the program or project which will be financed with Federal money, the dollar amount of Federal funds for the project or program, and percentage and a dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

34. Ensure that Management Memoranda responses are accurate, complete and received on or before the required response date.

35. Ensure compliance with the following requirements regarding imposition of charges for services, for those providers who charge for services:

    a. In the case of individuals with an income less than or equal to one hundred percent (100%) of federal poverty guidelines (FPG) (see www.aspe.hhs.gov/poverty), the provider will not impose charges on any such individual for the provision of services under the contract;

    b. In the case of individuals with an income greater than one hundred percent (100%) of the FPG, the provider:

        i. Will impose charges on each such individual for the provision of such services and
        ii. Will impose charges according to a schedule of charges that is made available to the public;

    c. In the case of individuals with an income between the FPG in Columns A and B (see table below), the provider will not, for any calendar year, impose charges exceeding the percentage in Column C of the client's annual gross income:

Column A: Client's income is greater than	Column B: Client's income does not exceed	Column C: Charges are not to exceed
100% of FPG	200% of FPG	5% of the client's annual gross income
200% of FPG	300% of FPG	7% of the client's annual gross income
300% of FPG	--	10% of the client's annual gross income

36. Cooperate with any Federal investigation regarding the Ryan White program funds.

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37. Participate in any state-mandated meetings, trainings, WebEx conferences, Webinars, teleconferences, and/or other conferences to be determined.

38. Take steps to ensure that people with limited English proficiency can meaningfully access health and social services. For detailed information on the specific responsibilities of Contractors regarding linguistic competence, see the Office of Civil Rights (OCR) website at: http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html

39. Ensure compliance contract Anti-Kickback Statute conditions (42 USC 1320a 7b(b). Processes and standards must be in place to avoid fraud, waste, and abuse (mismanagement) of Ryan White funds.

40. Ensure Ryan White Part B funding is only used to supplement and not supplant existing federal, state, or local funding for HIV testing, Health Insurance Premiums and cost sharing.

B. Monitoring Activities

The Contractor shall:

1. Conduct site visits and document/monitor the activities of subcontracted agencies to ensure contractual compliance not less than once every year. For all deficiencies cited in the contractor's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan.

2. Provide any necessary assistance to the State in carrying out State monitoring activities and inspection rights for both contractors and subcontracted agencies, as provided in this agreement.

3. Make available to authorized State and/or federal representatives all records, materials, data information, and appropriate staff required for monitoring or inspection activities.

4. For all deficiencies cited in the State's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan. Provide the corrective plan to the State within 30 days of receipt of the monitoring report.

C. Partner Services (PS)

The Contractor shall ensure that client service providers:

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1. Inform clients of the availability of PS. Client service providers may either offer PS directly through their agency or by referral to their designated local health programs.

2. Maintain documentation when PS is offered and the outcome (i.e., the number of partners to be notified by the client and/or by the health jurisdiction). Client service providers using ARIES should document these encounters on the Basic Medical screen. Client service providers not using ARIES should document these encounters in the client medical records.

D. Reporting Requirements

HCP Contractors are required to submit quarterly financial and narrative reports to OA. Financial Reports are to be submitted with the monthly / quarterly invoices. The HCP Quarterly Narrative Reports are due to OA according to the following schedule:

Reporting Period	Due dates
July 1 – September 30	November 15
October 1 – December 31	February 15
January 1 – March 31	May 15
April 1 – June 30	August 15

1. The quarterly HCP Financial Report tracks expenditures for the Contractor and any subcontracted agency for the quarter reported. The quarterly Financial Reports shall include the administrative costs of the Contractor and each subcontracted agency, amount of funds obligated to each subcontracted agency, total expended quarterly by each subcontracted agency, percentage expended for the quarter, and total number of unduplicated clients for the quarter reported.

2. The quarterly HCP Narrative Report is an opportunity for the Contractor to describe their HCP programs, services provided, progress and accomplishments, and to identify any technical assistance needs. The quarterly Narrative Reports shall include, for the quarter reported only, descriptions of the programs, services funded with HCP funds, any general accomplishments within the programs, issues or concerns with the programs and services funded in your county, and any technical assistance and/or training needs of the contractor and/or subcontracted agency.

   Contractors may access the HCP Financial and Narrative Report formats at:
   http://www.cdph.ca.gov/programs/aids/Pages/OAContractFY1112.aspx

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E. Data Collection

The Contractor shall ensure that client service providers:

1. Collect the HCP minimum data set. The HCP minimum dataset includes data elements required by (a) HRSA to complete the Ryan White Program Data Report (RDR), the Ryan White Program Service Report (RSR), selected HAB Quality Management (QM) indicators, and the Women, Infants, Children, and Youth Report, and (b) CDPH/OA for its development of estimates and reports (i.e., estimate of unmet need for HIV medical care, statewide epidemiologic profile, Statewide Coordinated Statement of Need) and to conduct program activities.

2. Directly enter data into ARIES within two weeks from a client's date of service. Client service providers may import data into ARIES from other data collection systems only if they obtain prior written approval from CDPH/OA; said providers may not use CDPH/OA funds to develop or maintain their import systems.

3. Electronically submit the aggregate-level RDR through HAB's Electronic Handbook (EHB). The RDR reporting period is January 1 through December 31 of the previous calendar. Submission deadlines will be announced in ARIES Policy Notices.

4. Electronically submit a Provider Report for the RSR through HAB's EHB. Unless exempted by HRSA, client service providers who provide RSR-eligible services must also upload a Client Report, which contains client-level data, as an XML data file to HAB's EHB. The RSR is due twice a year: (a) The first report includes data from the first six months of the current calendar year, and (b) The second report includes all the data from the entire previous calendar year. Submission deadlines will be announced in ARIES Policy Notices.

5. Comply with the policies and procedures outlined in ARIES Policy Notices issued by the CDPH/OA (see www.projectaries.org).

F. Client Service Provider/Subcontracted Agency Reporting Requirements

Comply with the State's timeline to submit to the State a list identifying the names and budget overview of all service provision and subcontracted agencies and total funds available to each Client Service Provider. OA's HIV Care Section will provide the required forms to complete the budget overview and all service provision information. These forms are located on the OA website. Please click on the link to access the current forms at http://www.cdph.ca.gov/programs/aids/Pages/OAContractFY1112.aspx

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G. Quality Management Program

The Contractor shall:

1. Ensure that all client service providers have a QM program in place. The QM program should fit within the framework of the client service providers' other programmatic quality assurance and quality improvement activities. Client service providers may use an existing QM program (e.g., Joint Commission on Accreditation of Healthcare Organizations, Medicaid) or develop their own program. Service providers may add additional program specific or other HAB indicators to their QM plan. The HAB QM Technical Assistance Manual can be accessed at ftp://ftp.hrsa.gov/hab/QM2003.pdf. HAB's performance measures Web page also contains a wealth of information, including more detailed descriptions of its performance measures and frequently asked questions (http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html).

2. Incorporate selected indicators from Groups 1 and 2 of HAB's HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents (also known as HAB QM indicators) into QM programs as CDPH/OA implements selected HAB QM indicators as part of its QM and monitoring program. Specific indicators will be identified and released by OA Management Memorandum. Contractors and subcontracted agencies can monitor their progress in meeting HAB QM indicators for Groups 1 and 2 by using the Compliance Reports in ARIES as appropriate.

3. Please refer to management memorandum 11-01 at *http://www.cdph.ca.gov/programs/aids/Pages/tOAHCPMAIsp.aspx* for more information.

H. Data Encryption

The Contractor shall adhere to the Information Privacy and Security Requirements (Exhibit J). In addition to the procedures set forth in the Information Privacy and Security Requirements exhibit, Contractors must ensure that all mobile devices are equipped with encryption software, even if the Contractor or their subcontracted agencies do not store confidential information on the mobile devices.

III. Minority AIDS Initiative (MAI)

1. MAI Services

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Minority AIDS Initiative (MAI) services must be targeted to HIV infected persons of color and must be planned and delivered in coordination with local HIV prevention outreach services to avoid duplication of effort. The goal of MAI is to increase access to, and engagement in, HIV/AIDS medical care for HIV-positive persons of color. This is achieved by providing outreach and treatment education services to HIV-infected persons of color who have never been in care, or who have been lost to care. For additional MAI information, please refer to the *MAI Budget Guidance..*

In accordance with HRSA guidance, OA has defined two MAI service categories, (1) outreach and (2) treatment education. Outreach and treatment education are the only allowable service categories for MAI funding. These service categories are designed to meet the needs of persons of color in order to ensure that minority clients can access, engage in, and remain in care; receive help in adhering to treatment; and be provided with education and support that will enable them to become active participants in their own health care and improve their overall quality of life. MAI outreach and treatment education services are defined as follows:

Outreach – Those activities typically performed by an outreach worker that results in: (1) Identifying HIV-infected persons of color who know their status but have never been in care or who have been lost to HIV medical care; (2) Removing barriers that have prevented access to HIV medical care, and (3) Establishing engagement in HIV medical care. Outreach services should be conducted at times and in places where there is a high probability that people of color with HIV infection will be reached.

MAI outreach services do not include routine HIV counseling and testing or HIV prevention education. These services may be provided on a case-by-case basis for a specific MAI client only when the service is necessary to remove a barrier to care for that client.

Treatment Education - The provision of health education, treatment adherence and risk reduction information to HIV-infected persons of color who know their HIV status but are not accessing medical care or to HIV-infected persons of color who are lost to care. Information includes educating clients living with HIV about how to communicate with medical providers, the importance of treatment adherence, how to manage medication side effects, how to understand their laboratory results, how to improve their health status, how to reduce HIV transmission, and identify medical and psychosocial support services and counseling that are available locally.

For designated county local health jurisdictions receiving additional HRSA funding specifically for MAI outreach and treatment education services to communities of color, the following services and standards must be adhered to:

1. The Contractor may provide direct client MAI services exclusively OR may subcontract all or part of the MAI outreach services. The Contractor must ensure that if all or part of the MAI client services are subcontracted to other service providers, all services provided by the subcontractor will be in accordance with the MAI funding and reporting requirements.

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2. The Contractor may employ MAI outreach staff or support other activities to identify HIV-infected persons of color who are out-of-care or lost-to-care and gradually engage them in appropriate HIV care and treatment services. Target populations are those out-of-care, HIV-infected persons of color who have been unable or unwilling to access services for HIV, despite an awareness of their positive serostatus. As a member of the HIV care program team, the outreach staff person will take actions to reduce or eliminate any cultural or other barriers that prevent access to and/or continued engagement in HIV care services. The Contractor must meet specific parameters to support the needs of this project. The parameters include the Contractor's ability to do the following:

   a. It is strongly recommended that MAI outreach staff be culturally and linguistically competent "street-level" workers who reflect the communities they serve**.** Highly recommended is experience in two or three of the following areas: street-based outreach, HIV counseling and testing, health education or HIV case management.

   b. MAI outreach staff are to take actions to reduce or eliminate any cultural or other barriers that prevent access to and/or continued engagement in care and treatment services. This individual links and supports the client in accessing suitable HIV care and treatment services.

   c. In lieu of outreach positions, MAI funds can also support outreach/treatment education activities or interventions for HIV-infected persons of color, as determined at the local level and approved by OA.

   d. Commit to submitting data in an accurate and timely fashion, including committing to full participation in any evaluation or research component.

   e. Be able to commit the MAI outreach worker to participate in ongoing staff trainings including but not limited to, attendance at various state-mandated meetings, trainings, Webex/teleconferences or conferences as required.

A. The Contractor shall:

   1. Provide services that identify and engage HIV-infected persons of color who know their HIV status but are not accessing medical care, to reach out to people of color who are HIV-infected but unaware of their HIV status, and/or to locate and reestablish access for HIV-infected persons of color who have been lost to care.

   2. Work with existing community resources and entities that serve as key points of entry into medical care, including but not limited to emergency rooms, substance abuse treatment programs, TCMP for those individuals released from state correctional institutions, detoxification centers, adult

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and juvenile detention facilities, STD clinics, HIV counseling and testing sites, mental health programs, homeless shelters, Federal Qualified Health Centers, etc. to coordinate and integrate HIV care service delivery.

3. Ensure that MAI outreach and treatment education services are planned and delivered in coordination with local HIV prevention outreach programs and other HIV services providers to avoid duplication of effort.

4. Ensure that services are responsive to the needs of the clients in the service area, are sensitive to linguistic, ethnic, and cultural differences of the population(s) being served, and that services are linguistically and culturally appropriate. Services may not be denied due to immigration status, place of residence within California, current or prior health condition, or inability to pay.

5. Ensure that PS is offered on a routine basis to all HIV-positive clients. Clients should be made aware that receiving assistance in the referral of partners is voluntary and will be offered periodically.

6. Ensure that MAI planning efforts are coordinated with all other local funding streams for HIV/AIDS to ensure that Ryan White HIV/AIDS program funds are the payer of last resort, maximize education and outreach efforts to link individuals to ADAP and other appropriate program, and reduce any duplication.

7. Ensure that client eligibility and service provision under this contract are in accordance with the CDPH/OA's *MAI Budget Guidance.* Screening and reassessment of client eligibility must be completed and documented every 6 months to determine continued eligibility for Ryan White services.

   Ensure that eligibility policies do not deem a Veteran living with HIV ineligible for Ryan White services due to eligibility for Department of Veterans Affairs (VA) health care benefits. Ensure policies and procedures classifying veterans receiving VA health benefits as uninsured, thus exempting these Veterans from the "Payer of Last Resort" requirement per Veterans Policy 07-07, Policy 04-01, and Parham Letter 08/04 (see www.hab.hrsa.gov).

8. Ensure that MAI clients have access to, and are enrolled in, ADAP, Medi-Cal, or other appropriate program(s) providing HIV medications.

9. Ensure HIV care services will be provided in a setting that is accessible to low-income individuals with HIV disease. Facilities must also be accessible for hearing-, vision-, and mobility-impaired persons in accordance with the federal ADA.

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10. Ensure the protection of the client's privacy and confidentiality at all times. In addition, federal law requires that individuals have a right of access, to inspect, and obtain a copy of their PHI in a designated record set, for as long as the health information is maintained by a CDPH health plan, CDPH providers, or business associates. There are limited exceptions to an individual's right of access PHI (45 C.F.R. s 164.524).

11. Ensure that any subcontractors have the organizational and administrative capabilities to support the program services and activities. The Contractor is responsible for quality assurance and utilization review activities for subcontracted MAI services.

12. Ensure that any subcontractors have appropriate facilities and resources, including an adequate physical plant and appropriate supplies and equipment available for the provision of services and practical support functions.

13. Ensure that all service providers have a QM program in place. The QM activities should fit within the framework of the Contractor's or subcontractor's other programmatic quality assurance and quality improvement activities. Contractors and subcontractors may use an existing QM program or develop their own program. Service providers may add additional program specific or other HAB indicators to their QM plan. The HAB QM Technical Assistance Manual can be accessed at ftp://ftp.hrsa.gov/hab/QM2003.pdf. HAB's performance measures Web page also contains a wealth of information, including more detailed descriptions of its performance measures and frequently asked questions (http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html). It is strongly recommended that HAB Group 1, 2, and 3 indicators be incorporated into QM programs because CDPH/OA is planning to track selected HAB QM indicators as part of its QM program.

14. Ensure that no more than ten percent (10%) of the allocation is used for non-direct service functions such as:

    a. Routine contract administration and monitoring activities, including the preparation of applications for these funds, the receipt and disbursal of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine programmatic and financial reports, and compliance with contract conditions and audit requirements;

    b. All activities associated with the Contractor's subcontract award procedures, including the development of request for proposals, contract proposal review activities, negotiation and awarding of subcontracts, grievance process, monitoring of subcontracts

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through telephone consultation or onsite visits, reporting on subcontracts and funding reallocation activities.

15. In addition, ensure that no more than ten percent (10%) of the allocation is used for all subcontractors' non-direct service (administrative) functions.

16. Ensure that service providers who provide Medi-Cal reimbursable services are certified as providers for purposes of Medi-Cal billing (see www.medi-cal.ca.gov) and have the ability to bill other third-party payers for covered services.

17. Ensure that funds are payer of last resort by ensuring that service providers bill all other third party payers, including Medi-Cal, before invoicing MAI.

18. Ensure that funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service:

    a. Under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

    b. By an entity that provides health services on a prepaid basis.

19. Funded service providers should integrate, and work collaboratively, with other such services and coordinate with other available programs (including Medicaid), to ensure continuity of care and prevention of services of individuals with HIV is enhanced.

20. Ensure funds are not used on prohibited activities (see www.hab.hrsa.gov) and CDPH/OA's HCP and Budget Guidelines.

21. Prohibit employees from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.

    a. Documentation is required by the Compliance Plan or employee conduct standards that prohibit employees from receiving payments in kind or cash from suppliers and contractors of goods or services.

22. Ensure that funds are not used to:

    a. Purchase or improve any building or other facility, with the exception of minor repairs or remodeling approved in writing by the State;

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b. Pay for automobile parts, repairs, or maintenance, pet care or supplies, funeral expenses, etc. (see www.hab.hrsa.gov); or

c. Make cash payment to intended recipients of services.

d. Develop, promote, or advertise about HIV services that target the general public.

e. Generate broad scope awareness activities about HIV services that target the general public.

f. Pay costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools), or to pay any amount expended by a State under Title XIX of the Social Security Act.

g. Pay for any item or service that can reasonably be expected to be paid under any State Compensation program, insurance policy, or any Federal or State Health Benefits Program (except for programs related to Indian Health Service);

h. Pay for any item or service that can paid by an entity that provides health services on a prepaid basis;

i. For the development of materials, designed to promote or encourage, directly or indirectly, intravenous drug use or sexual activity;

23. Ensure that all approved subcontractor invoices are paid by the Contractor within 45 days of receipt.

24. Ensure that funds are not carried over into subsequent contract years.

25. Ensure compliance with the federal HRSA Ryan White Program, CDPH/OA's *MAI Budget Guidance,* CDPH/OA Policy Letters, Management Memoranda, AIDS Regional Information and Evaluation System (ARIES) Policy Notices, and other program guidelines issued by CDPH/OA.

26. Ensure compliance with the following requirements regarding imposition of charges for services, for those providers who charge for services:

a. In the case of individuals with an income less than or equal to one hundred percent (100%) of FPG (see www.aspe.hhs.gov/poverty),

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the provider will not impose charges on any such individual for the provision of services under the contract;

b. In the case of individuals with an income greater than one hundred percent (100%) of the FPG, the provider:

   i. Will impose charges on each such individual for the provision of such services and
   ii. Will impose charges according to a schedule of charges that is made available to the public;

c. In the case of individuals with an income between the FPG in Columns A and B (see table below), the provider will not, for any calendar year, impose charges exceeding the percentage in Column C of the client's annual gross income:

Column A: Client's income is greater than	Column B: Client's income does not exceed	Column C: Charges are not to exceed
100% of FPG	200% of FPG	5% of the client's annual gross income
200% of FPG	300% of FPG	7% of the client's annual gross income
300% of FPG	--	10% of the client's annual gross income

27. Cooperate with any Federal investigation regarding the Ryan White program funds.

28. Participate in any state-mandated meetings, trainings, WebEx conferences, teleconferences, and/or other conferences to be determined.

29. Administer MAI funds appropriately, maintain records and invoices using standard accounting practices, coordinate federal and state data reporting, and arrange for fiscal audits.

30. When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, the Contractor shall clearly state the percentage of the total costs of the program or project which will

be financed with Federal money, the dollar amount of Federal funds for the project or program, and percentage and a dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

31. Take steps to ensure that people with limited English proficiency can meaningfully access health and social services. For detailed information on the specific responsibilities of Contractors regarding linguistic competence, see the OCR website at: http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html.

32. Ensure compliance contract Anti-Kickback Statute conditions (42 USC 1320a 7b(b). Processes and standards must be in place to avoid fraud, waste, and abuse (mismanagement) of Ryan White funds.

33. Ensure Ryan White Part B MAI funding is only used to supplement and not supplant existing federal, state, or local funding for HIV testing, Health Insurance Premiums and cost sharing.

B. Monitoring Activities

The Contractor shall:

1. Conduct site visits and document/monitor the activities of subcontracted agencies to ensure contractual compliance not less than once every year. For all deficiencies cited in the contractor's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan.

2. Provide any necessary assistance to the State in carrying out State monitoring activities and inspection rights for both contractors and subcontracted agencies, as provided in this agreement.

3. Make available to authorized State and/or federal representatives all records, materials, data information, and appropriate staff required for monitoring or inspection activities.

4. For all deficiencies cited in the State's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan. Provide the corrective plan to the State within 30 days of receipt of the monitoring report.

C. Reporting Requirements

Each MAI contractor is required to submit an MAI Quarterly Narrative Status Report. The MAI Quarterly Narrative Status reports are due to OA according to the following schedule:

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REPORTING PERIODS	DUE DATES
July 1 – September 30, 2011	November 15
October 1 – December 31, 2011	February 15
January 1 – March 31, 2012	May 15
April 1 – June 30, 2012	August 15

1. The quarterly MAI Narrative Status Report is an opportunity for the Contractor to provide program accomplishments, successful outreach and/or treatment education strategies, challenges and lessons learned, problems or issues, and requests for training and technical assistance, in addition to reporting numbers of clients served and the types of services provided.

Contractors may access the Narrative Report format at: http://www.cdph.ca.gov/programs/aids. Each MAI contractor, on an annual or as needed basis, must comply with the State's timeline to submit to the State a list identifying the names and budget overview of all service providers and subcontracted agencies and total funds for service provision that are available to each. OA MAI will provide the required forms to complete the budget overview and all service provision information. These forms are located on the OA website.

D. Data Collection

1. Until MAI reporting is incorporated into the State's ARIES data reporting system, Contractors receiving MAI funds for outreach and treatment education services must track and report activities manually. Both forms, *MAI Demographic Reporting Form* and *MAI Client Contact Reporting Form*, are to be submitted to OA on a monthly basis either via fax or email. These forms may be accessed via OA's website.

2. Ensure compliance with all CDPH/OA Policy Letters, Management Memoranda, ARIES Policy Notices, and other policies and procedures issued by CDPH/OA.

E. Data Encryption

The Contractor shall adhere to the Information Privacy and Security Requirements (Exhibit J). In addition to the procedures set forth in the Information Privacy and Security exhibit, Contractors must ensure that all mobile devices are equipped with encryption software, even if the Contractor or their subcontracted agencies do not store confidential information on the mobile devices.

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I. Introduction

1. Mission Statement

The goals of the California Department of Public Health, Office of AIDS (CDPH/OA) are: (1) to minimize new HIV infections and (2) to maximum the number of people with HIV infection who access appropriate care, treatment, support, and prevention services. The services required by the HIV Care Program (HCP) and Minority AIDS Initiative (MAI) Scopes of Work (SOWs) in this Memorandum of Understanding are consistent with, and are designed to support, these goals.

2. Service Overview

CDPH/OA utilizes federal Health Resources Services Administration (HRSA) funds to provide support for HIV/AIDS services in local areas. Federal HRSA funds include Part B and Minority AIDS Initiative funding. HIV care services are funded using a Single Allocation Model to consolidate HRSA program funds into a single contract in each local health jurisdiction or service area.

Through this single contract, the Contractor agrees to administer (A) **HCP** and, if applicable, *(*B) **MAI Outreach and Treatment Education Services**.

A. The Contractor agrees to administer HCP and to ensure the provision of the HIV care services as described in this SOW. The Contractor may provide direct client services exclusively or subcontract all or part of the client services. The Contractor ensures that, if all or parts of the client services are subcontracted to other client service providers, all services provided by the subcontracted agency will be in accordance with HCP

B. If funded, the Contractor agrees to administer the MAI outreach and treatment education services focused on providing access to, and engagement in, medical care for HIV-positive persons of color, including access to AIDS Drug Assistance Program (ADAP), Medi-Cal, or other appropriate program

II. HIV Care Program

1. HCP Services

The HIV care services to be provided under HCP are HRSA-defined service categories. For a listing of HRSA service category definitions, and the specific services included in each category, please refer to the HRSA website at www.hab.hrsa.gov. Additional information can be found in the *HCP and Budget Guidelines.*

CDPH/OA will not require local utilization of HRSA's "75 percent (Core services) / 25 percent (Support services)" requirement for prioritization of services.

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HCP is a two-tiered approach to service prioritization and delivery and utilizes the HRSA-defined service categories, both the Core and Support service categories.

HCP prioritizes service provisions as follows:

Tier One: *Outpatient/Ambulatory Medical Care,* as defined by HRSA. Services include, but are not limited to, primary medical care, laboratory testing, medical history taking, health screening, and prescribing and managing medications. Contractors must ensure that Tier One medical services are provided for all population groups in their geographic region via all HIV/AIDS or other funding sources before allocating HCP funds to Tier Two services.

Tier Two: HRSA-defined Core and Support service categories that (1) assist with access to Tier One care, (2) support maintenance in Tier One care, and (3) reduce the risk of treatment failure and/or HIV transmission. HCP funds may be allocated for any Tier Two service only after Contractors have ensured Tier One services are adequately provided in their geographic region via all HIV/AIDS or other funding sources.

The following HRSA service categories are included in Tier Two of HCP:

- *Mental Health Services*
- *Medical Case Management Svcs (includes Treatment Adherence)*
- *Case Management (Non-Medical)*
- *Oral Health Care*
- *AIDS Pharmaceutical Assistance*
- *Substance Abuse Services - Outpatient and Residential*
- *Health Education/Risk Reduction*
- *Home Health Care*
- *Hospice Services*
- *Outreach Services*
- *Emergency Financial Assistance*
- *Food Bank/Home-Delivered Meals*
- *Housing Services*
- *Legal Services*
- *Treatment Adherence Counseling*
- *Health Insurance Premium and Cost Sharing Assistance*
- *Home- and Community-Based Health Services*
- *Linguistic Services*
- *Medical Transportation Services*
- *Psychosocial Support Services*
- *Medical Nutrition Therapy*
- *Early Intervention Services*
- *Referral for Health Care/Supportive Services*
- *Rehabilitation Services*
- *Respite Care*
- *Child Care Services*

A. The Contractor shall:

1. Provide comprehensive, ongoing medical services to individuals with HIV/AIDS. Services must be based on the HRSA service category, *Outpatient/Ambulatory Medical Care* or, if these services are not funded by HCP under Tier One, the Contractor must demonstrate and document the availability of primary medical care for HIV-infected persons within each population group in the service area.

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2. Provide Tier Two HRSA Core and Support services as necessary, and as funds permit, to ensure access to Tier One care, maintenance in Tier One care, and reduce the risk of treatment failure or HIV transmission.

3. Develop and implement a system of service delivery that offers comprehensive, ongoing health and support services to individuals with HIV/AIDS, that actively seeks individuals who know their HIV status but are not accessing services, that reaches out to people who are HIV positive but unaware of their HIV status, and that is coordinated and integrated with other service delivery systems as appropriate.

4. Advisory and/or focus groups will meet at least **annually** to provide input to the Contractor on issues such as needs assessment, service delivery plans, and comprehensive planning. The Contractor shall maintain minutes and/or documentation of the advisory or focus group meetings.

   The advisory and/or focus group, should be made up of representatives from state, federal, and local programs that provide health services and education and prevention services; non-profit and for-profit community-based agencies; staff from other key points of entry into medical care, who either provide services to individuals with HIV/AIDS, or who may have contact with HIV positive individuals who are not in care or not aware of their HIV status; individuals with HIV, and their advocates, etc. The advisory group provides information to the Contractor regarding health services delivery and the needs of individuals with HIV/AIDS living within the community.

5. Ensure the protection of the client's privacy and confidentiality at all times. In addition, federal law requires that individuals have a right of access, to inspect, and obtain a copy of their protected health information (PHI) in a designated record set, for as long as the health information is maintained by a CDPH health plan, CDPH providers, or business associates. There are limited exceptions to an individual's right of access PHI (45 C.F. R. s 164.524).

6. Ensure that any subcontracted agencies have the organizational and administrative capabilities to support the program services and activities. The Contractor is responsible for quality assurance and utilization review activities for subcontracted HIV care services.

7. Ensure that any subcontracted agencies have appropriate facilities and resources, including an adequate physical plant and appropriate supplies and equipment available for the provision of services and practical support functions.

8. Develop and maintain working relationships, and coordinate an integrated system of service delivery, with entities who provide key points of entry

into medical care, including but not limited to emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, California Department of Corrections and Rehabilitation, Transitional Case Management Program (TCMP) for incarcerated populations, sexually transmitted disease (STD) clinics, HIV counseling and testing sites, mental health programs, homeless shelters, health care points of entry specified by the State, federally qualified health centers, migrant health centers, community health centers, health services for the homeless, family planning grantees, comprehensive hemophilia diagnostic and treatment centers, and non-profit and for profit private entities that provide comprehensive primary care services to populations at risk for HIV. The coordinated, integrated system of care must be informed by HIV epidemiological data and other data sources and should include leveraged resources. The Contractor shall keep documentation of these working relationships.

9. Ensure that case management services that link available community support services to appropriate specialized medical services shall be provided for individuals residing in rural areas as appropriate.

10. Ensure HIV care services will be provided in a setting that is accessible to low-income individuals with HIV disease. Facilities must also be accessible for hearing-, vision-, and mobility-impaired persons in accordance with the federal Americans with Disabilities Act (ADA).

11. Provide targeted prevention coordinated with all state and federal programs to low-income individuals with HIV disease and to inform such individuals of the services available under Ryan White Part B.

12. To the maximum extent practical, ensure that HIV-related health care and support services delivered pursuant to a program established with assistance provided under Ryan White Part B will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual with HIV disease.

13. Ensure that services provided to women, infants, children, and youth are tracked and reported (see Data Collection, subheading F).

14. Ensure that services provided under this contract are in accordance with the program policy guidance issued by Division of Service Systems (DSS), HIV/AIDS Bureau (HAB) (see www.hab.hrsa.gov), CDPH/OA's *HCP and Budget Guidelines.*

15. Ensure that the Ryan White HIV/AIDS Program funds do not comprise more than sixty percent (60%) of any subcontracted agency's total budget. Ryan White HIV/AIDS Program funds are intended to provide

additional funding to those areas negatively affected by HIV disease and cannot be used to supplant local HIV-related budgets.

16. Ensure that clients are eligible for Ryan White services in accordance with the program policy guidance issued by DSS, HAB (see www.hab.hrsa.gov). Screening and reassessment of client eligibility must be completed and documented every 6 months to determine continued eligibility for Ryan White services.

    Ensure that eligibility policies do not deem a Veteran living with HIV ineligible for Ryan White services due to eligibility for Department of Veterans Affairs (VA) health care benefits. Ensure policies and procedures classifying veterans receiving VA health benefits as uninsured, thus exempting these Veterans from the "Payer of Last Resort" requirement per Veterans Policy 07-07, Policy 04-01, and Parham Letter 08/04 (see www.hab.hrsa.gov).

17. Ensure that no more than ten percent (10%) of the allocation is used for non-direct service functions such as:

    a. Routine contract administration and monitoring activities, including the preparation of applications for these funds, the receipt and disbursal of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine programmatic and financial reports, and compliance with contract conditions and audit requirements;

    b. All activities associated with the Contractor's subcontract award procedures, including the development of request for proposals, contract proposal review activities, negotiation and awarding of subcontracts, grievance process, monitoring of subcontracts through telephone consultation or onsite visits, reporting on subcontracts and funding reallocation activities.

18. In addition, ensure that no more than ten percent (10%) of the allocation is used for all subcontracted agencies' non-direct service (administrative) functions without prior written consent from OA.

19. Conduct assessment of HIV/AIDS service needs for the geographic service area at least once every three years. Review the assessment annually and, if needed, update it. Ensure that no more than five percent (5%) of the allocation is utilized to plan, conduct, and evaluate the needs assessment process. Needs assessment activities may not be billed to CDPH/OA more than once during a three year contract period.

20. Ensure that client service providers who provide Medi-Cal reimbursable services are certified as providers for purposes of Medi-Cal billing (see

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www.medi-cal.ca.gov) and have the ability to bill other third-party payers for covered services.

21. Ensure that funds are payer of last resort by ensuring that client service providers bill all other third-party payers, including Medi-Cal, before invoicing HCP.

22. Funded service providers should integrate, and work collaboratively, with other such services and coordinate with other available programs (including Medicaid), to ensure continuity of care and prevention of services of individuals with HIV is enhanced.

23. Ensure documentation of written referral relationships with entities considered key points of access to healthcare systems for the purpose of facilitating early intervention services for individuals diagnosed as being HIV positive.

    a. Work with consortia, service providers, and individuals with HIV/AIDS to identify key points of entry.
    b. Monitor the use of referral and linkage agreements by funded service providers.

24. Ensure funds are not used on prohibited activities (see www.hrsa.hab.gov) and CDPH/OA's HCP and Budget Guidelines.

25. Prohibit employees from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.

    a. Documentation is required by the Compliance Plan or employee conduct standards that prohibit employees from receiving payments in kind or cash from suppliers and contractors of goods or services.

26. Ensure that funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service:

    a. Under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

    b. By an entity that provides health services on a prepaid basis.

27. Ensure that funds are not used to:

    a. Make cash payment to intended recipients of services;

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b. Develop, promote, or advertise about HIV services that target the general public.

c. Generate broad scope awareness activities about HIV services that target the general public.

d. Pay costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools), or to pay any amount expended by a State under Title XIX of the Social Security Act.

e. Pay for any item or service that can reasonably be expected to be paid under any State Compensation program, insurance policy, or any Federal or State Health Benefits Program (except for programs related to Indian Health Service);

f. Pay for any item or service that can paid by an entity that provides health services on a prepaid basis;

g. For the development of materials, designed to promote or encourage, directly or indirectly, intravenous drug use or sexual activity;

h. Purchase or improve (other than minor remodeling) any building or other facility; or

i. Pay for automobile parts, repairs, or maintenance, pet care or supplies, funeral expenses, etc. (see www.hab.hrsa.gov).

28. Ensure that all approved subcontracted agency invoices are paid within 45 days of receipt.

29. Ensure that no funds are carried over into subsequent contract years.

30. Ensure compliance with the federal HRSA Ryan White Program, CDPH/OA's *HCP and Budget Guidelines,* CDPH/OA Policy Letters, Management Memoranda, AIDS Regional Information and Evaluation System (ARIES) Policy Notices, and other program guidelines issued by CDPH/OA.

31. Administer Ryan White Part B funds appropriately, maintain records and invoices using standard accounting practices, coordinate federal and state data reporting, and arrange for fiscal audits.

32. Annually evaluate the cost-effectiveness of the mechanisms used to deliver comprehensive care.

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33. When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, the Contractor shall clearly state the percentage of the total costs of the program or project which will be financed with Federal money, the dollar amount of Federal funds for the project or program, and percentage and a dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

34. Ensure that Management Memoranda responses are accurate, complete and received on or before the required response date.

35. Ensure compliance with the following requirements regarding imposition of charges for services, for those providers who charge for services:

    a. In the case of individuals with an income less than or equal to one hundred percent (100%) of federal poverty guidelines (FPG) (see www.aspe.hhs.gov/poverty), the provider will not impose charges on any such individual for the provision of services under the contract;

    b. In the case of individuals with an income greater than one hundred percent (100%) of the FPG, the provider:

        i. Will impose charges on each such individual for the provision of such services and
        ii. Will impose charges according to a schedule of charges that is made available to the public;

    c. In the case of individuals with an income between the FPG in Columns A and B (see table below), the provider will not, for any calendar year, impose charges exceeding the percentage in Column C of the client's annual gross income:

Column A: Client's income is greater than	Column B: Client's income does not exceed	Column C: Charges are not to exceed
100% of FPG	200% of FPG	5% of the client's annual gross income
200% of FPG	300% of FPG	7% of the client's annual gross income
300% of FPG	--	10% of the client's annual gross income

36. Cooperate with any Federal investigation regarding the Ryan White program funds.

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37. Participate in any state-mandated meetings, trainings, WebEx conferences, Webinars, teleconferences, and/or other conferences to be determined.

38. Take steps to ensure that people with limited English proficiency can meaningfully access health and social services. For detailed information on the specific responsibilities of Contractors regarding linguistic competence, see the Office of Civil Rights (OCR) website at: http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html

39. Ensure compliance contract Anti-Kickback Statute conditions (42 USC 1320a 7b(b). Processes and standards must be in place to avoid fraud, waste, and abuse (mismanagement) of Ryan White funds.

40. Ensure Ryan White Part B funding is only used to supplement and not supplant existing federal, state, or local funding for HIV testing, Health Insurance Premiums and cost sharing.

B. Monitoring Activities

The Contractor shall:

1. Conduct site visits and document/monitor the activities of subcontracted agencies to ensure contractual compliance not less than once every year. For all deficiencies cited in the contractor's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan.

2. Provide any necessary assistance to the State in carrying out State monitoring activities and inspection rights for both contractors and subcontracted agencies, as provided in this agreement.

3. Make available to authorized State and/or federal representatives all records, materials, data information, and appropriate staff required for monitoring or inspection activities.

4. For all deficiencies cited in the State's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan. Provide the corrective plan to the State within 30 days of receipt of the monitoring report.

C. Partner Services (PS)

The Contractor shall ensure that client service providers:

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1. Inform clients of the availability of PS. Client service providers may either offer PS directly through their agency or by referral to their designated local health programs.

2. Maintain documentation when PS is offered and the outcome (i.e., the number of partners to be notified by the client and/or by the health jurisdiction). Client service providers using ARIES should document these encounters on the Basic Medical screen. Client service providers not using ARIES should document these encounters in the client medical records.

D. Reporting Requirements

HCP Contractors are required to submit quarterly financial and narrative reports to OA. Financial Reports are to be submitted with the monthly / quarterly invoices. The HCP Quarterly Narrative Reports are due to OA according to the following schedule:

Reporting Period	Due dates
July 1 – September 30	November 15
October 1 – December 31	February 15
January 1 – March 31	May 15
April 1 – June 30	August 15

1. The quarterly HCP Financial Report tracks expenditures for the Contractor and any subcontracted agency for the quarter reported. The quarterly Financial Reports shall include the administrative costs of the Contractor and each subcontracted agency, amount of funds obligated to each subcontracted agency, total expended quarterly by each subcontracted agency, percentage expended for the quarter, and total number of unduplicated clients for the quarter reported.

2. The quarterly HCP Narrative Report is an opportunity for the Contractor to describe their HCP programs, services provided, progress and accomplishments, and to identify any technical assistance needs. The quarterly Narrative Reports shall include, for the quarter reported only, descriptions of the programs, services funded with HCP funds, any general accomplishments within the programs, issues or concerns with the programs and services funded in your county, and any technical assistance and/or training needs of the contractor and/or subcontracted agency.

   Contractors may access the HCP Financial and Narrative Report formats at:
   http://www.cdph.ca.gov/programs/aids/Pages/OAContractFY1112.aspx

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E. Data Collection

The Contractor shall ensure that client service providers:

1. Collect the HCP minimum data set. The HCP minimum dataset includes data elements required by (a) HRSA to complete the Ryan White Program Data Report (RDR), the Ryan White Program Service Report (RSR), selected HAB Quality Management (QM) indicators, and the Women, Infants, Children, and Youth Report, and (b) CDPH/OA for its development of estimates and reports (i.e., estimate of unmet need for HIV medical care, statewide epidemiologic profile, Statewide Coordinated Statement of Need) and to conduct program activities.

2. Directly enter data into ARIES within two weeks from a client's date of service. Client service providers may import data into ARIES from other data collection systems only if they obtain prior written approval from CDPH/OA; said providers may not use CDPH/OA funds to develop or maintain their import systems.

3. Electronically submit the aggregate-level RDR through HAB's Electronic Handbook (EHB). The RDR reporting period is January 1 through December 31 of the previous calendar. Submission deadlines will be announced in ARIES Policy Notices.

4. Electronically submit a Provider Report for the RSR through HAB's EHB. Unless exempted by HRSA, client service providers who provide RSR-eligible services must also upload a Client Report, which contains client-level data, as an XML data file to HAB's EHB. The RSR is due twice a year: (a) The first report includes data from the first six months of the current calendar year, and (b) The second report includes all the data from the entire previous calendar year. Submission deadlines will be announced in ARIES Policy Notices.

5. Comply with the policies and procedures outlined in ARIES Policy Notices issued by the CDPH/OA (see www.projectaries.org).

F. Client Service Provider/Subcontracted Agency Reporting Requirements

Comply with the State's timeline to submit to the State a list identifying the names and budget overview of all service provision and subcontracted agencies and total funds available to each Client Service Provider. OA's HIV Care Section will provide the required forms to complete the budget overview and all service provision information. These forms are located on the OA website. Please click on the link to access the current forms at http://www.cdph.ca.gov/programs/aids/Pages/OAContractFY1112.aspx

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G. Quality Management Program

The Contractor shall:

1. Ensure that all client service providers have a QM program in place. The QM program should fit within the framework of the client service providers' other programmatic quality assurance and quality improvement activities. Client service providers may use an existing QM program (e.g., Joint Commission on Accreditation of Healthcare Organizations, Medicaid) or develop their own program. Service providers may add additional program specific or other HAB indicators to their QM plan. The HAB QM Technical Assistance Manual can be accessed at ftp://ftp.hrsa.gov/hab/QM2003.pdf. HAB's performance measures Web page also contains a wealth of information, including more detailed descriptions of its performance measures and frequently asked questions (http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html).

2. Incorporate selected indicators from Groups 1 and 2 of HAB's HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents (also known as HAB QM indicators) into QM programs as CDPH/OA implements selected HAB QM indicators as part of its QM and monitoring program. Specific indicators will be identified and released by OA Management Memorandum. Contractors and subcontracted agencies can monitor their progress in meeting HAB QM indicators for Groups 1 and 2 by using the Compliance Reports in ARIES as appropriate.

3. Please refer to management memorandum 11-01 at *http://www.cdph.ca.gov/programs/aids/Pages/tOAHCPMAIsp.aspx* for more information.

H. Data Encryption

The Contractor shall adhere to the Information Privacy and Security Requirements (Exhibit J). In addition to the procedures set forth in the Information Privacy and Security Requirements exhibit, Contractors must ensure that all mobile devices are equipped with encryption software, even if the Contractor or their subcontracted agencies do not store confidential information on the mobile devices.

III. Minority AIDS Initiative (MAI)

1. MAI Services

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Minority AIDS Initiative (MAI) services must be targeted to HIV infected persons of color and must be planned and delivered in coordination with local HIV prevention outreach services to avoid duplication of effort. The goal of MAI is to increase access to, and engagement in, HIV/AIDS medical care for HIV-positive persons of color. This is achieved by providing outreach and treatment education services to HIV-infected persons of color who have never been in care, or who have been lost to care. For additional MAI information, please refer to the *MAI Budget Guidance..*

In accordance with HRSA guidance, OA has defined two MAI service categories, (1) outreach and (2) treatment education. Outreach and treatment education are the only allowable service categories for MAI funding. These service categories are designed to meet the needs of persons of color in order to ensure that minority clients can access, engage in, and remain in care; receive help in adhering to treatment; and be provided with education and support that will enable them to become active participants in their own health care and improve their overall quality of life. MAI outreach and treatment education services are defined as follows:

Outreach – Those activities typically performed by an outreach worker that results in: (1) Identifying HIV-infected persons of color who know their status but have never been in care or who have been lost to HIV medical care; (2) Removing barriers that have prevented access to HIV medical care, and (3) Establishing engagement in HIV medical care. Outreach services should be conducted at times and in places where there is a high probability that people of color with HIV infection will be reached.

MAI outreach services do not include routine HIV counseling and testing or HIV prevention education. These services may be provided on a case-by-case basis for a specific MAI client only when the service is necessary to remove a barrier to care for that client.

Treatment Education - The provision of health education, treatment adherence and risk reduction information to HIV-infected persons of color who know their HIV status but are not accessing medical care or to HIV-infected persons of color who are lost to care. Information includes educating clients living with HIV about how to communicate with medical providers, the importance of treatment adherence, how to manage medication side effects, how to understand their laboratory results, how to improve their health status, how to reduce HIV transmission, and identify medical and psychosocial support services and counseling that are available locally.

For designated county local health jurisdictions receiving additional HRSA funding specifically for MAI outreach and treatment education services to communities of color, the following services and standards must be adhered to:

1. The Contractor may provide direct client MAI services exclusively OR may subcontract all or part of the MAI outreach services. The Contractor must ensure that if all or part of the MAI client services are subcontracted to other service providers, all services provided by the subcontractor will be in accordance with the MAI funding and reporting requirements.

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2. The Contractor may employ MAI outreach staff or support other activities to identify HIV-infected persons of color who are out-of-care or lost-to-care and gradually engage them in appropriate HIV care and treatment services. Target populations are those out-of-care, HIV-infected persons of color who have been unable or unwilling to access services for HIV, despite an awareness of their positive serostatus. As a member of the HIV care program team, the outreach staff person will take actions to reduce or eliminate any cultural or other barriers that prevent access to and/or continued engagement in HIV care services. The Contractor must meet specific parameters to support the needs of this project. The parameters include the Contractor's ability to do the following:

    a. It is strongly recommended that MAI outreach staff be culturally and linguistically competent "street-level" workers who reflect the communities they serve**.** Highly recommended is experience in two or three of the following areas: street-based outreach, HIV counseling and testing, health education or HIV case management.

    b. MAI outreach staff are to take actions to reduce or eliminate any cultural or other barriers that prevent access to and/or continued engagement in care and treatment services. This individual links and supports the client in accessing suitable HIV care and treatment services.

    c. In lieu of outreach positions, MAI funds can also support outreach/treatment education activities or interventions for HIV-infected persons of color, as determined at the local level and approved by OA.

    d. Commit to submitting data in an accurate and timely fashion, including committing to full participation in any evaluation or research component.

    e. Be able to commit the MAI outreach worker to participate in ongoing staff trainings including but not limited to, attendance at various state-mandated meetings, trainings, Webex/teleconferences or conferences as required.

A. The Contractor shall:

1. Provide services that identify and engage HIV-infected persons of color who know their HIV status but are not accessing medical care, to reach out to people of color who are HIV-infected but unaware of their HIV status, and/or to locate and reestablish access for HIV-infected persons of color who have been lost to care.

2. Work with existing community resources and entities that serve as key points of entry into medical care, including but not limited to emergency rooms, substance abuse treatment programs, TCMP for those individuals released from state correctional institutions, detoxification centers, adult

and juvenile detention facilities, STD clinics, HIV counseling and testing sites, mental health programs, homeless shelters, Federal Qualified Health Centers, etc. to coordinate and integrate HIV care service delivery.

3. Ensure that MAI outreach and treatment education services are planned and delivered in coordination with local HIV prevention outreach programs and other HIV services providers to avoid duplication of effort.

4. Ensure that services are responsive to the needs of the clients in the service area, are sensitive to linguistic, ethnic, and cultural differences of the population(s) being served, and that services are linguistically and culturally appropriate. Services may not be denied due to immigration status, place of residence within California, current or prior health condition, or inability to pay.

5. Ensure that PS is offered on a routine basis to all HIV-positive clients. Clients should be made aware that receiving assistance in the referral of partners is voluntary and will be offered periodically.

6. Ensure that MAI planning efforts are coordinated with all other local funding streams for HIV/AIDS to ensure that Ryan White HIV/AIDS program funds are the payer of last resort, maximize education and outreach efforts to link individuals to ADAP and other appropriate program, and reduce any duplication.

7. Ensure that client eligibility and service provision under this contract are in accordance with the CDPH/OA's *MAI Budget Guidance.* Screening and reassessment of client eligibility must be completed and documented every 6 months to determine continued eligibility for Ryan White services.

   Ensure that eligibility policies do not deem a Veteran living with HIV ineligible for Ryan White services due to eligibility for Department of Veterans Affairs (VA) health care benefits. Ensure policies and procedures classifying veterans receiving VA health benefits as uninsured, thus exempting these Veterans from the "Payer of Last Resort" requirement per Veterans Policy 07-07, Policy 04-01, and Parham Letter 08/04 (see www.hab.hrsa.gov).

8. Ensure that MAI clients have access to, and are enrolled in, ADAP, Medi-Cal, or other appropriate program(s) providing HIV medications.

9. Ensure HIV care services will be provided in a setting that is accessible to low-income individuals with HIV disease. Facilities must also be accessible for hearing-, vision-, and mobility-impaired persons in accordance with the federal ADA.

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10. Ensure the protection of the client's privacy and confidentiality at all times. In addition, federal law requires that individuals have a right of access, to inspect, and obtain a copy of their PHI in a designated record set, for as long as the health information is maintained by a CDPH health plan, CDPH providers, or business associates. There are limited exceptions to an individual's right of access PHI (45 C.F.R. s 164.524).

11. Ensure that any subcontractors have the organizational and administrative capabilities to support the program services and activities. The Contractor is responsible for quality assurance and utilization review activities for subcontracted MAI services.

12. Ensure that any subcontractors have appropriate facilities and resources, including an adequate physical plant and appropriate supplies and equipment available for the provision of services and practical support functions.

13. Ensure that all service providers have a QM program in place. The QM activities should fit within the framework of the Contractor's or subcontractor's other programmatic quality assurance and quality improvement activities. Contractors and subcontractors may use an existing QM program or develop their own program. Service providers may add additional program specific or other HAB indicators to their QM plan. The HAB QM Technical Assistance Manual can be accessed at ftp://ftp.hrsa.gov/hab/QM2003.pdf. HAB's performance measures Web page also contains a wealth of information, including more detailed descriptions of its performance measures and frequently asked questions (http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html). It is strongly recommended that HAB Group 1, 2, and 3 indicators be incorporated into QM programs because CDPH/OA is planning to track selected HAB QM indicators as part of its QM program.

14. Ensure that no more than ten percent (10%) of the allocation is used for non-direct service functions such as:

    a. Routine contract administration and monitoring activities, including the preparation of applications for these funds, the receipt and disbursal of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine programmatic and financial reports, and compliance with contract conditions and audit requirements;

    b. All activities associated with the Contractor's subcontract award procedures, including the development of request for proposals, contract proposal review activities, negotiation and awarding of subcontracts, grievance process, monitoring of subcontracts

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through telephone consultation or onsite visits, reporting on subcontracts and funding reallocation activities.

15. In addition, ensure that no more than ten percent (10%) of the allocation is used for all subcontractors' non-direct service (administrative) functions.

16. Ensure that service providers who provide Medi-Cal reimbursable services are certified as providers for purposes of Medi-Cal billing (see www.medi-cal.ca.gov) and have the ability to bill other third-party payers for covered services.

17. Ensure that funds are payer of last resort by ensuring that service providers bill all other third party payers, including Medi-Cal, before invoicing MAI.

18. Ensure that funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service:

    a. Under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

    b. By an entity that provides health services on a prepaid basis.

19. Funded service providers should integrate, and work collaboratively, with other such services and coordinate with other available programs (including Medicaid), to ensure continuity of care and prevention of services of individuals with HIV is enhanced.

20. Ensure funds are not used on prohibited activities (see www.hab.hrsa.gov) and CDPH/OA's HCP and Budget Guidelines.

21. Prohibit employees from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.

    a. Documentation is required by the Compliance Plan or employee conduct standards that prohibit employees from receiving payments in kind or cash from suppliers and contractors of goods or services.

22. Ensure that funds are not used to:

    a. Purchase or improve any building or other facility, with the exception of minor repairs or remodeling approved in writing by the State;

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b. Pay for automobile parts, repairs, or maintenance, pet care or supplies, funeral expenses, etc. (see www.hab.hrsa.gov); or

c. Make cash payment to intended recipients of services.

d. Develop, promote, or advertise about HIV services that target the general public.

e. Generate broad scope awareness activities about HIV services that target the general public.

f. Pay costs associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools), or to pay any amount expended by a State under Title XIX of the Social Security Act.

g. Pay for any item or service that can reasonably be expected to be paid under any State Compensation program, insurance policy, or any Federal or State Health Benefits Program (except for programs related to Indian Health Service);

h. Pay for any item or service that can paid by an entity that provides health services on a prepaid basis;

i. For the development of materials, designed to promote or encourage, directly or indirectly, intravenous drug use or sexual activity;

23. Ensure that all approved subcontractor invoices are paid by the Contractor within 45 days of receipt.

24. Ensure that funds are not carried over into subsequent contract years.

25. Ensure compliance with the federal HRSA Ryan White Program, CDPH/OA's *MAI Budget Guidance,* CDPH/OA Policy Letters, Management Memoranda, AIDS Regional Information and Evaluation System (ARIES) Policy Notices, and other program guidelines issued by CDPH/OA.

26. Ensure compliance with the following requirements regarding imposition of charges for services, for those providers who charge for services:

a. In the case of individuals with an income less than or equal to one hundred percent (100%) of FPG (see www.aspe.hhs.gov/poverty),

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the provider will not impose charges on any such individual for the provision of services under the contract;

b. In the case of individuals with an income greater than one hundred percent (100%) of the FPG, the provider:

   i. Will impose charges on each such individual for the provision of such services and
   ii. Will impose charges according to a schedule of charges that is made available to the public;

c. In the case of individuals with an income between the FPG in Columns A and B (see table below), the provider will not, for any calendar year, impose charges exceeding the percentage in Column C of the client's annual gross income:

Column A: Client's income is greater than	Column B: Client's income does not exceed	Column C: Charges are not to exceed
100% of FPG	200% of FPG	5% of the client's annual gross income
200% of FPG	300% of FPG	7% of the client's annual gross income
300% of FPG	--	10% of the client's annual gross income

27. Cooperate with any Federal investigation regarding the Ryan White program funds.

28. Participate in any state-mandated meetings, trainings, WebEx conferences, teleconferences, and/or other conferences to be determined.

29. Administer MAI funds appropriately, maintain records and invoices using standard accounting practices, coordinate federal and state data reporting, and arrange for fiscal audits.

30. When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, the Contractor shall clearly state the percentage of the total costs of the program or project which will

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be financed with Federal money, the dollar amount of Federal funds for the project or program, and percentage and a dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

31. Take steps to ensure that people with limited English proficiency can meaningfully access health and social services. For detailed information on the specific responsibilities of Contractors regarding linguistic competence, see the OCR website at: http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html.

32. Ensure compliance contract Anti-Kickback Statute conditions (42 USC 1320a 7b(b). Processes and standards must be in place to avoid fraud, waste, and abuse (mismanagement) of Ryan White funds.

33. Ensure Ryan White Part B MAI funding is only used to supplement and not supplant existing federal, state, or local funding for HIV testing, Health Insurance Premiums and cost sharing.

B. Monitoring Activities

The Contractor shall:

1. Conduct site visits and document/monitor the activities of subcontracted agencies to ensure contractual compliance not less than once every year. For all deficiencies cited in the contractor's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan.

2. Provide any necessary assistance to the State in carrying out State monitoring activities and inspection rights for both contractors and subcontracted agencies, as provided in this agreement.

3. Make available to authorized State and/or federal representatives all records, materials, data information, and appropriate staff required for monitoring or inspection activities.

4. For all deficiencies cited in the State's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan. Provide the corrective plan to the State within 30 days of receipt of the monitoring report.

C. Reporting Requirements

Each MAI contractor is required to submit an MAI Quarterly Narrative Status Report. The MAI Quarterly Narrative Status reports are due to OA according to the following schedule:

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REPORTING PERIODS	DUE DATES
July 1 – September 30, 2011	November 15
October 1 – December 31, 2011	February 15
January 1 – March 31, 2012	May 15
April 1 – June 30, 2012	August 15

1. The quarterly MAI Narrative Status Report is an opportunity for the Contractor to provide program accomplishments, successful outreach and/or treatment education strategies, challenges and lessons learned, problems or issues, and requests for training and technical assistance, in addition to reporting numbers of clients served and the types of services provided.

Contractors may access the Narrative Report format at: http://www.cdph.ca.gov/programs/aids. Each MAI contractor, on an annual or as needed basis, must comply with the State's timeline to submit to the State a list identifying the names and budget overview of all service providers and subcontracted agencies and total funds for service provision that are available to each. OA MAI will provide the required forms to complete the budget overview and all service provision information. These forms are located on the OA website.

D. Data Collection

1. Until MAI reporting is incorporated into the State's ARIES data reporting system, Contractors receiving MAI funds for outreach and treatment education services must track and report activities manually. Both forms, *MAI Demographic Reporting Form* and *MAI Client Contact Reporting Form*, are to be submitted to OA on a monthly basis either via fax or email. These forms may be accessed via OA's website.

2. Ensure compliance with all CDPH/OA Policy Letters, Management Memoranda, ARIES Policy Notices, and other policies and procedures issued by CDPH/OA.

E. Data Encryption

The Contractor shall adhere to the Information Privacy and Security Requirements (Exhibit J). In addition to the procedures set forth in the Information Privacy and Security exhibit, Contractors must ensure that all mobile devices are equipped with encryption software, even if the Contractor or their subcontracted agencies do not store confidential information on the mobile devices.