Ryan White HIV/AIDS Program

Part A

Policies & Procedures Manual

NY EMA Subrecipient Staff

July 2024

Contents

How to Use the Manual

This manual provides subrecipients with crucial information on managing their Ryan White HIV/AIDS Program (RWHAP) Part A-funded Subaward Agreement. This includes general information including HRSA policies, regulations, and legislation, as well as information on the role of each stakeholder. Subrecipients should refer to their Subaward Agreements from Public Health Solutions (PHS), on behalf and at the direction of the New York City Department of Health and Mental Hygiene (NYC Health Department), for specific terms and conditions.

Section 1: Ryan White HIV/AIDS Program Overview

1.1 The Ryan White HIV/AIDS Program[1]

The Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of care that includes primary medical care and essential support services for people with HIV (PWH) who are uninsured or underinsured. RWHAP works with cities, states, and local community-based organizations to provide HIV care and treatment services to more than half a million people each year. RWHAP reaches over half of all people diagnosed with HIV in the United States.

The RWHAP legislation is known as the Ryan White HIV/AIDS Treatment Extension Act of 2009 and is also Title XXVI of the Public Health Service Act. First passed in 1990 as the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act, the RWHAP helps PWH get into care early, stay in care, and remain healthy. Many decisions about how to use the money funds are made by local planning councils/planning bodies and state planning groups, which work as partners with their governments.

RWHAP is administered by the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA).

1.2 Ryan White HIV/AIDS Program Funding[2]

The RWHAP legislation supports grants under the five sections of the Act: Parts A, B, C, D, and F. Below is a short description of each Part of RWHAP.

- RWHAP Part A: Grant funding given to eligible metropolitan areas (EMAs) and transitional grant areas (TGAs) hardest hit by the epidemic for HIV medical care and support services. Approximately 72% of all PWH in the United States are living in EMAs and TGAs.[3]
- RWHAP Part B: Grant funding given to states and territories for HIV medical care and support services, including HIV-related medications through the AIDS Drug Assistance Program.
- RWHAP Part C: Community-based early intervention services grants for HIV medical care and support services.
- RWHAP Part D: Community-based grants for family-centered primary and specialty medical care and support services for infants, children, youth, and women living with HIV.
- RWHAP Part F: Grant funding which supports five programs—Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETCs), HIV Dental Programs, and the Minority AIDS Initiative (MAI).

1.3 HIV Care Continuum[4]

The HIV Care Continuum provides a framework that depicts the series of stages a PWH engages in, from initial diagnosis to successful treatment with HIV medication. The Continuum consists of five stages: Diagnosis, Linkage to Care, Receipt of Care, Retained in Care, and Viral Suppression. The HIV Care Continuum allows recipients and planning groups to measure progress and to direct HIV resources most effectively. ***Subrecipients of RWHAP grant funds are encouraged to assess the outcomes of their programs along this continuum of care***.

1.4 National HIV/AIDS Strategy[5]

The National HIV/AIDS Strategy (2022–2025) provides stakeholders across the nation with a roadmap to accelerate efforts to end the HIV epidemic in the United States by 2030. The Strategy reflects the commitment to re-energize and strengthen a whole-of-society response to the epidemic while supporting PWH and reducing HIV-associated morbidity and mortality.

---

[1] JSI Research and Training Institute et al., "Ryan White HIV/AIDS Program Part A Planning Council Primer" (June 2018), pg. 5, https://targethiv.org/sites/default/files/file-upload/resources/Primer_June2018.pdf.
[2] JSI Research and Training Institute et al., "Ryan White HIV/AIDS Program Part A Planning Council Primer" (June 2018), pg. 6-10, https://targethiv.org/sites/default/files/file-upload/resources/Primer_June2018.pdf.
[3] HIV/AIDS Bureau, Health Resources and Services Administration, US Department of Health and Human Services, "Ryan White HIV/AIDS Program Part A Manual" (Manual, Division of Metropolitan HIV/AIDS Programs, March 2023), pg. 3, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf.
[4] HIV/AIDS Bureau, Health Resources and Services Administration, US Department of Health and Human Services, "Ryan White HIV/AIDS Program Part A Manual" (Manual, Division of Metropolitan HIV/AIDS Programs, March 2023), pg. 24-25, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf.
[5] HIV/AIDS Bureau, Division of State HIV/AIDS Programs, "Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients" (June 2022), https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf.

The Strategy sets bold targets for ending the HIV epidemic in the United States by 2030, including a 75% reduction in new HIV infections by 2025 and a 90% reduction by 2030. To guide the nation toward realizing the vision, the Strategy focuses on four goals:

1. Prevent new HIV infections.
2. Improve HIV-related health outcomes of PWH.
3. Reduce HIV-related disparities and health inequities.
4. Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders.

The RWHAP promotes robust advances and innovations in HIV health care using the National HIV/AIDS Strategy as its framework to end the epidemic.[6]

1.5 Ending the HIV Epidemic

Ending the HIV Epidemic in the U.S.

The federal Ending the HIV Epidemic in the U.S. (EHE) initiative aims to reduce the number of new HIV infections in the United States by at least 90 percent by 2030. The plan leverages critical scientific advances in HIV prevention, diagnosis, treatment, and outbreak response by coordinating the highly successful programs, resources, and infrastructure of many HHS agencies. By design, the EHE initiative is closely aligned and complementary to the National HIV/AIDS Strategy. While the Strategy is the broader, overarching plan that extends across the nation, the EHE initiative is a collaborative effort between the HHS and state, tribal, and local partners, focused on implementing the Strategy.[7]

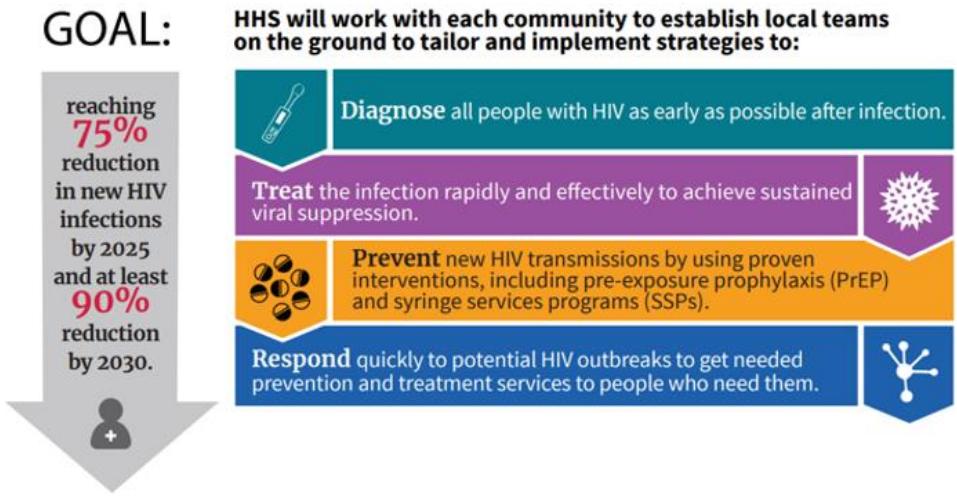

Figure 1. EHE Goals

Ending the AIDS Epidemic in New York State[8]

In response to the federal EHE Plan, New York State announced a three-point plan in 2014 aimed at ending the AIDS epidemic in New York State. The three-point plan:

1. Identifies PWH who remain undiagnosed and links them to health care;
2. Links and retains persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission; and
3. Facilitates access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

[6] HIV/AIDS Bureau, Health Resources and Services Administration, US Department of Health and Human Services, "Ryan White HIV/AIDS Program Part A Manual" (Manual, Division of Metropolitan HIV/AIDS Programs, March 2023), pg. 12, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf.
[7] HIV.gov, "What is Ending the HIV Epidemic in the US?" (July 01, 2022), https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview/
[8] New York State Department of Health, "Ending the AIDS Epidemic in New York State," New York State Department of Health, accessed April 9, 2023, https://www.health.ny.gov/diseases/aids/ending_the_epidemic/.

Ending the Epidemic (ETE) in New York State aims to maximize the availability of lifesaving, transmission-interrupting treatment for HIV, saving lives and improving the health of New Yorkers. It will move New York away from its history of having the worst HIV epidemic in the country to a future where new infections are rare and those living with the disease have normal lifespans with few complications. New York State pledges to reach ETE goals and end the epidemic by the end of 2024.

The RWHAP Part A grant awarded to the New York EMA includes the five boroughs of New York City (NYC)—Bronx, Brooklyn, Manhattan, Queens, and Staten Island—and the adjacent Lower Hudson Valley (Tri-County) region of Westchester, Rockland, and Putnam Counties. RWHAP Part A programs in the NY EMA play an integral role in helping New York State reach its ETE goals.

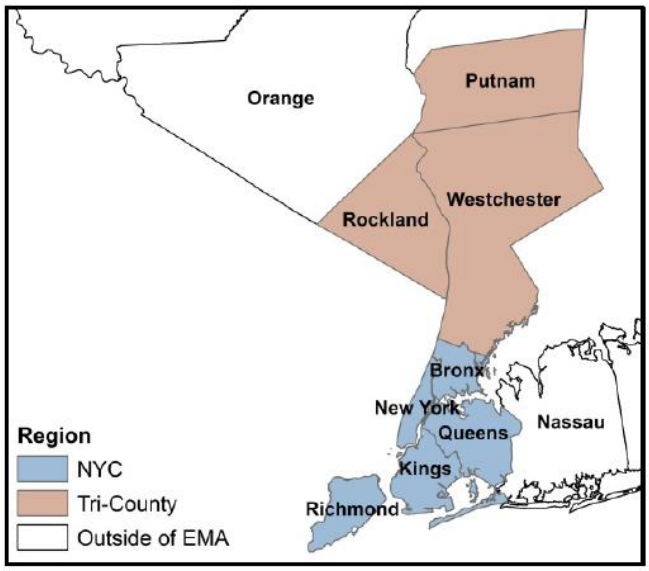

Figure 2. Map of the NY EMA

Section 2: Ryan White HIV/AIDS Program Part A Stakeholders

2.1 How RWHAP Part A Works[9]

The goal of RWHAP Part A is to provide optimal HIV care and treatment for low-income and uninsured or underinsured PWH residing in an EMA or TGA to improve their health outcomes. This section describes the people and entities that participate in RWHAP Part A and their roles. The participants in the RWHAP Part A grant for the NY EMA include the following:

- The chief elected official (CEO), who receives the funds on behalf of the EMA. In the NY EMA, this is the NYC's Mayor.
- The recipient, the entity chosen by the CEO to manage the grant and make sure funds are used appropriately. In the NY EMA, this is the NYC Health Department (see 2.2).
- The planning council (or planning body), which conducts planning, decides how to allocate resources, and works to ensure a system of care that provides equitable access to care and services to all eligible PWH in the EMA.
- The HRSA HIV/AIDS Bureau's Division of Metropolitan HIV/AIDS Programs (HAB/DMHAP) is the federal government entity within HRSA that ensures the RWHAP Part A program is implemented appropriately.

2.2 RWHAP Part A Recipient in the NY EMA

The designated Recipient for the RWHAP Part A grant in the NY EMA is the NYC Department of Health and Mental Hygiene (NYC Health Department). Specifically, the HIV Care and Treatment Program (CTP) located within the Bureau of Hepatitis, HIV, and Sexually Transmitted Infections (BHHS) of the NYC Health Department is responsible for overseeing

[9]JSI Research and Training Institute et al., "Ryan White HIV/AIDS Program Part A Planning Council Primer" (June 2018), pg. 11, https://targethiv.org/sites/default/files/file-upload/resources/Primer_June2018.pdf.

and directing both the RWHAP Part A grant and local ETE funding related to HIV care and treatment. CTP is also responsible for managing the Housing Opportunities for Persons with AIDS (HOPWA) grant for New York. The Director of CTP serves as both the Project Director for the RWHAP Part A grant in the NY EMA and as the Recipient on the HIV Health and Human Services Planning Council of New York (NY Planning Council). The Recipient is accountable to HRSA for managing RWHAP Part A funds and awarding funds to organizations to provide services that are identified by the NY Planning Council as priorities. Funds are usually awarded to organizations through a competitive "Request for Proposals" (RFP) process. Organizations selected through the RFP process to provide direct services using RWHAP Part A funds are considered subrecipients and are responsible for adequate oversight and monitoring of their programs as outlined in the terms and conditions of their subaward agreement.

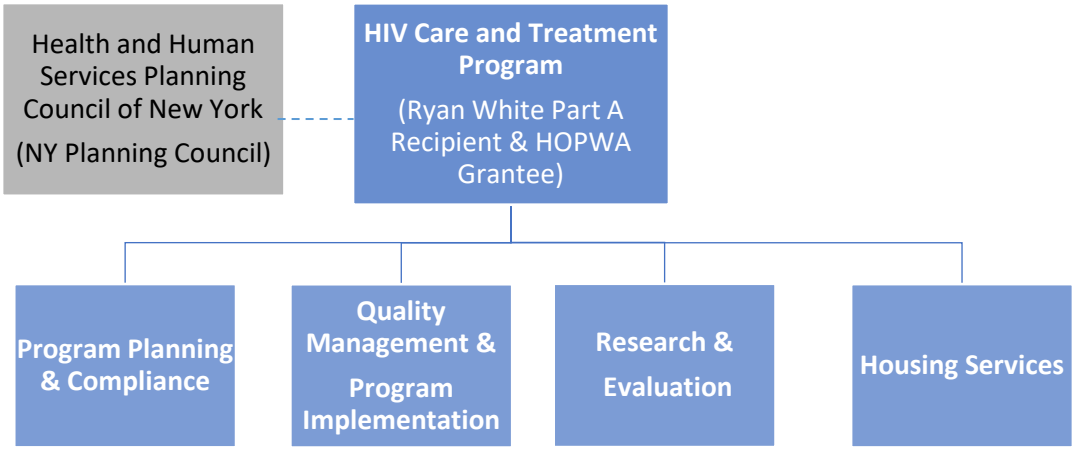

Figure 3. CTP Org Chart

As noted in Figure 3 above, the CTP team is comprised of four units:

1. *Program Planning and Compliance (PPC)* – The PPC unit manages all program planning, procurement, and grant compliance and management for the RWHAP Part A federal grant received from HRSA HAB. This includes, but is not limited to, working with the NY HIV Planning Council (PC) to help set priorities, allocate funding, and develop program priorities and service directives for HIV care and treatment services based on current and emerging needs of PWH in the NY EMA. The team oversees the RFP process and other types of procurement related to the provision of RWHAP Part A approved services to eligible clients. The Program Planning and Compliance unit is also responsible for leading the development of a health equity framework, principles, and tools to address disparities among PWH in the NY EMA. Additionally, the unit leads the timely and accurate submission of all reporting requirements to HRSA and ensures compliance pursuant to the federal, state, and local regulations. Lastly, the Program Planning and Compliance unit works alongside the Project Director of the HRSA-20-078 Ending the HIV Epidemic grant to identify unmet needs in the RWHAP Part A portfolio in the NY EMA and leverage funds outside of the portfolio to help fill gaps otherwise not addressed through the implementation of the RWHAP Part A program in the NY EMA.

2. *Quality Management and Program Implementation (QMPI)* – The QMPI unit leads the NY EMA Clinical Quality Management (CQM) Program, including the development of the quality management (QM) plan and the facilitation of the QM committee. QMPI provides programmatic monitoring, implementation support, and quality management capacity building to all RWHAP Part A subrecipients. The QMPI unit also collaborates with New York State Department of Health AIDS Institute (AI) to offer a range of QM and quality improvement (QI) trainings and peer learning opportunities to RWHAP Part A subrecipients and consumers.

3. *Research and Evaluation Unit (REU)* – The REU conducts program evaluation and research, data systems design and documentation, federal reporting, and performance measurement for services in the RWHAP Part A NY EMA, local ETE programs, and HOPWA. The REU is responsible for fulfilling data requests from a wide range of stakeholders (NY Planning Council, RWHAP Part A programs, public officials, and other agencies, including HRSA) and overseeing the annual Ryan White HIV/AIDS Services Report (RSR) to HRSA.

4. *Housing Services Unit (HSU)* – The HSU manages and supports both the RWHAP Part A and HOPWA housing services portfolios, ensuring housing regulations align with guidance from both HUD (Department of Housing and Urban Development) and HRSA. HSU embraces the **Housing is Healthcare** approach, which promotes stable permanent housing as a means to improve and maintain health outcomes for PWH.

CTP Vision and Mission
Through consistent internal and external collaboration, CTP aims to achieve the program-approved vision and mission, while practicing the program's Core Values:

1. *CTP Vision Statement*: A community where all people with HIV have their health needs met and enjoy a high-quality, dignified life that is free of HIV stigma, racism, and other systems of oppression.
2. *CTP Mission Statement:* To re-imagine care, treatment, and housing for PWH through equity-driven processes of informing, planning, and supporting quality service implementation.
3. *CTP Core Values:* Equity, Humility, Collaboration, and Accountability

2.4 HIV Health and Human Services Planning Council of New York (NY Planning Council)

The NY Planning Council is the planning body appointed by the NYC Mayor to plan the organization and delivery of HIV services funded by RWHAP Part A. Each Council member is a caring, dedicated volunteer who has been carefully selected to reflect the diversity of the NY EMA, with members representing the general public, PWH, funded service providers, and other health and social service organizations. Council members work together to identify the care needs of PWH, determine which services are of the highest priority, and how much funding should be committed to each service category. Council members also evaluate the cost effectiveness and the quality of the services provided.[10] The NY Planning Council is responsible for deciding what services are priorities for funding and how much funding should be allocated for each service category based upon the needs of PWH in the NY EMA.

The NY Planning Council does much of its work through committees. Per the RWHAP Part A PC Primer, "committees typically discuss issues, develop plans or recommendations, and bring them to the executive committee for review and possible revision. Then the recommendations go to the full planning council for final discussion and action."[11] The NY Planning Council committees include:

1. *The Executive Committee* – serves as the "board of directors" of the NY Planning Council. Comprised of the Council leadership, including all committee chairs, the Executive Committee provides overall leadership and guidance, sets work plans and agendas for the NY Planning Council, and oversees the work of the other committees.

2. *The Consumer Committee* – oversees efforts to ensure meaningful and substantial involvement of PWH in all NY Planning Council activities and is by invite only.

3. *The Needs Assessment Committee* – manages all required needs assessment activities, including data analysis, selecting topics to investigate to contribute to the NY Planning Council's assessment of local needs for services, review of epidemiological and service utilization data, and estimating and assessing unmet need and service gaps.

4. *The Integration of Care Committee* – reviews and recommends ways to strengthen the system of care in the EMA and describes services that will address needs identified through needs assessments by developing innovative service models and standards of care.

5. *The Priority Setting & Resource Allocation Committee* – is charged with determining the funding amounts for all service categories in the RWHAP Part A portfolio for the NY EMA. This Committee also ranks each service category in priority order based on a set of pre-determined criteria.

[10] HIV Health and Human Services Planning Council of New York, "About Us," NY HIV Planning Council, (2022), https://nyhiv.org/about-2/.
[11] JSI Research and Training Institute et al., "Ryan White HIV/AIDS Program Part A Planning Council Primer" (June 2018), pg. 16, https://targethiv.org/sites/default/files/file-upload/resources/Primer_June2018.pdf.

6. *The Tri-County Steering Committee* - conducts all planning activities (needs assessment, service directives, priority setting and resource allocation) for the Lower Hudson Valley/Tri-County region of Westchester, Rockland, and Putnam Counties. This Committee is comprised of consumers, providers, and community members from the Tri-County region.

The Framing Directive, created and approved by the NY Planning Council in December 2021, applies to all service directives in the NY EMA and seeks to reduce health outcomes disparities among PWH to ensure that RWHAP Part A services are equitable and stigma-free and that all eligible PWH benefit from effective HIV interventions.

Establishing service standards is a shared responsibility of the recipient and the Planning Council. Service standards, which are required by HRSA for all RWHAP Part A funded service categories in an EMA, guide RWHAP Part A-funded subrecipients in implementing services. Service standards typically address the elements and expectations for service delivery, such as service components, intake and eligibility, personnel qualifications, and client rights and responsibilities. The service standards set the minimum requirements of a service and serve as a base on which the recipient's clinical quality management (CQM) program is built. Service standards related to HRSA RWHAP Part A Core Medical Services must be consistent with U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as other pertinent clinical and professional standards. Service standards related to HRSA RWHAP Part A Support Services may be developed using evidence-based or evidence-informed best practices, the most recent HRSA RWHAP Parts A and B National Monitoring Standards, and guidelines developed by the state and local government.

2.6 Subrecipients[12]

A subrecipient is a non-federal entity that receives a subaward from a pass-through entity (PTE) to carry out part of a federal program. Subrecipients must use funds for authorized purposes only and must remain in compliance with federal statutes, regulations, and the terms and conditions of the subaward for the entire term of their subaward. In the NY EMA, RWHAP Part A subrecipients provide core medical and support services to eligible clients. These subrecipients include ambulatory medical clinics, non-profit organizations, and faith-based and community-based organizations.

Public Health Solutions (PHS), a private non-profit, entered into a contractual agreement with the NY Health Department to administer subaward agreements for BHHS. For RWHAP Part A-funded services, PHS, on behalf and at the direction of BHHS, releases RFPs; manages the procurement processes; enters into subaward agreements; monitors subrecipients performance (including compliance with subaward terms and conditions); and processes payments for reasonable, allowable, and allocable costs. Monitoring efforts led by PHS include reviewing reports and deliverables and conducting site visits.

CTP and PHS work together to ensure optimized performance for subrecipients. This includes collaboration on the development of site visits tools, drafting guidance to subrecipients (e.g., RWHAP Part A documentation standards), and provision of technical assistance.

Section 3: Ryan White HIV/AIDS Program Part A Policy

RWHAP Part A is governed by federal regulations and program-specific policies. Subrecipients are expected to have a clear understanding of these policy documents and all requirements and the expectations therein.[13]

These include:

- The RWHAP Legislation;
- The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 CFR 75; and

[12] HIV/AIDS Bureau, Health Resources and Services Administration, US Department of Health and Human Services, "Ryan White HIV/AIDS Program Part A Manual" (Manual, Division of Metropolitan HIV/AIDS Programs, March 2023), pg. 80, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf.
[13] HIV/AIDS Bureau, Health Resources and Services Administration, US Department of Health and Human Services, "Ryan White HIV/AIDS Program Part A Manual" (Manual, Division of Metropolitan HIV/AIDS Programs, March 2023), pg. 9, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf.

- HHS and HRSA Grants Administration and Program-Specific Policies, which include:
  - HHS Grants Policy Statement (GPS);
  - Notices of Funding Opportunity (NOFOs);
  - Notices of Award (NoAs);
  - HRSA HAB Policy Notices;
  - HRSA HAB Program Letters;
  - RWHAP Part A Manual; and
  - RWHAP Recipient Resources, including the RWHAP Parts A and B National Monitoring Standards (NMS).

3.1 RWHAP Part A National Monitoring Standards (NMS) & Policy Clarification Notices (PCNs)

The RWHAP Part A NMS consolidate the requirements set forth in relevant authorities and outline suggested standards for how RWHAP Part A recipients and subrecipients can meet those requirements. As such, the NMS do not establish or impose legislative, regulatory, or programmatic requirements; rather, they provide guidance on how RWHAP Part A recipients, lead agencies, and consortia can meet requirements for Part A program and fiscal management, monitoring, and reporting.[14]

Policy Clarification Notices (PCNs) are used by HRSA to define and clarify RWHAP statutory requirements[15] for recipients, subrecipients, and planning bodies. It should be noted that PCNs are not instructions on how to manage RWHAPs, as recipients have flexibility in making decisions within the framework of each RWHAP policy[16]. All PCNs play an important role in the administration of RWHAPs. However, the PCNs highlighted in this section are considered vital to the successful implementation of RWHAP Part A-funded subrecipients' programs.

3.2 Determining Client Eligibility & Payor of Last Resort PCN 21-02

PCN 21-02 outlines HRSA HAB's guidance for RWHAP for determining client eligibility and complying with the payor of last resort requirement, while minimizing administrative burden and enhancing continuity of care and treatment services.

Client Eligibility[17]

People are eligible to receive RWHAP Part A services when they meet each of the following three factors:

1. HIV Status
   a. A documented diagnosis of HIV is required. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds and as otherwise stipulated by HRSA HAB.)
      i. As part of the NY EMA grant, Part A subrecipients are required to obtain and maintain documentation of HIV-positive status once an individual is enrolled in services. RWHAP Part A funds must not be used to provide services to individuals known to be HIV-negative or to have an unknown HIV status, with limited exceptions for dependents of an HIV-positive client.[18]
2. Low-income
   a. The RWHAP Part A recipient defines low-income. It may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

[14] HIV/AIDS Bureau, Division of State HIV/AIDS Programs, "Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients" (June 2022), 3, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf.
[15] Antigone Dempsey, "Policy Clarification Notices - RWHAP Part B Administrative Reverse Site Visit," (October 23, 2019), pg. 7, https://targethiv.org/sites/default/files/supporting-files/Day_1_Policy_Clarification_Notices_Dempsey.pdf.
[16] Antigone Dempsey, "Policy Clarification Notices - RWHAP Part B Administrative Reverse Site Visit," (October 23, 2019), pg. 8, https://targethiv.org/sites/default/files/supporting-files/Day_1_Policy_Clarification_Notices_Dempsey.pdf
[17] HIV/AIDS Bureau, HRSA, "PCN 21-02 Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program" (October 19, 2021), pg. 1-2, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-21-02-determining-eligibility-polr.pdf
[18] Public Health Solutions, "Addendum 1, Client Eligibility Addendum", (March 2024), pg. 1

   i. As part of the NY EMA grant, all new and continuing clients enrolled in funded programs must meet income eligibility requirements to receive services. The NY Planning Council has set the maximum household income at 500% of the Federal Poverty Level (FPL).[19]

3. Residency
   a. The RWHAP Part A recipient defines its residency criteria within its service area. (Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP Part A services. RWHAP Part A recipients or subrecipients should not share immigration status with immigration enforcement agencies.)
      i. As part of the NY EMA grant, all new and continuing clients enrolled in programs must provide documentation of residency in the NY EMA (i.e., one of the five boroughs of New York City or Putnam, Rockland, or Westchester counties).[20]

Several RWHAP Part A service categories within the NY EMA also have **additional eligibility requirements or waivers** such as housing status, medical diagnoses of specific conditions, or others, as required by HRSA. *Refer to your subrecipient agreement for information on other applicable eligibility requirements.*

Best Practices to Track and Document Eligibility

RWHAP Part A subrecipients should conduct periodic checks to identify any potential changes that may affect eligibility and require clients to report any such changes. In the NY EMA, client eligibility criteria must be verified by subrecipients' staff within 90 days of enrollment, annually (annual verification can include client self-attestation), and every two years at full recertification (with supporting documentation).[21] Subrecipients should use electronic data sources (e.g., Medicaid enrollment, state tax filings, enrollment and eligibility information collected from health care marketplaces) to collect and verify client eligibility information, such as income and health care coverage (that includes income limitations), when possible. RWHAP Part A recipients and subrecipients should first use available data sources to confirm client eligibility before requesting additional information from the client. If the RWHAP Part A client still meets the eligibility criteria based on recent, reliable, and available data, recipients and subrecipients may renew that client's eligibility without requesting additional information from the individual.

Payor of Last Resort[22]

RWHAP is considered the payor of last resort (POLR) for eligible clients, and, in accordance with the RWHAP legislation, funds may not be used for any item or service "to the extent that payment has been made, or can reasonably be expected to be made under…any State compensation program, under an insurance policy, or under any Federal or State health benefits program…, or by an entity that provides health services on a pre-paid basis."

Guidance on Complying with the POLR Requirement: RWHAP subrecipients must ensure that reasonable efforts are made to use non-RWHAP resources whenever possible, including establishing, implementing, and monitoring policies and procedures to identify any other possible payers to extend finite RWHAP funds. RWHAP subrecipients must maintain policies and document their efforts to ensure that they assist clients to vigorously pursue enrollment in health care coverage and that clients have accessed all other available public and private funding sources for which they may be eligible. RWHAP subrecipients may continue providing services funded through RWHAP to a client who remains unenrolled in other health care coverage so long as there is rigorous documentation that such coverage was vigorously pursued. RWHAP subrecipients should conduct periodic checks to identify any potential changes to clients' healthcare coverage that may affect whether the RWHAP remains the payor of last resort and require clients to report any such changes.

Coverage of Services by the Ryan White HIV/ AIDS Program

RWHAP funds may be used to fill in coverage gaps for individuals who are either underinsured or uninsured to maintain access to care and treatment services, as allowable and defined by the RWHAP. RWHAP funds may be used for core

[19] Public Health Solutions, "Addendum 1, Client Eligibility Addendum", (March 2024), pg. 1
[20] Public Health Solutions, "Addendum 1, Client Eligibility Addendum", (March 2024), pg. 1
[21] Public Health Solutions, "Addendum 1, Client Eligibility Addendum", (March 2024), pg. 1
[22] HIV/AIDS Bureau, HRSA, "PCN 21-02 Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program" (October 19, 2021), pg. 2-3, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-21-02-determining-eligibility-polr.pdf

medical and support services if those services are not covered or are only partially covered by another payer, even when those services are provided at the same visit.

3.3 Payor of Last Resort (POLR) Considerations in the NY EMA

POLR Requirements

In the NY EMA, RWHAP Part A subrecipients must coordinate with other RWHAP Parts (Part B, C and F) when similar services are provided. This is essential to avoid duplication of provided services or payments. Subrecipients may not be reimbursed for services that are payable by Medicaid. In addition to the services available to all Medicaid enrollees, there are supplemental services available to enrollees who qualify for and are enrolled in additional Medicaid-funded programs. These additional programs include HIV Special Needs Plans (SNPS), Health Homes (HH), Health and Recovery Plans (HARPS), and Home and Community Based Services (HCBS). While compliance with POLR will be assessed and enforced for Medicaid reimbursable services, RWHAP Part A subrecipients are obligated to treat RWHAP Part A as the POLR in the presence of any non-RWHAP source of funding.[23]

Service Categories and POLR in the NY EMA

1. Service Categories Exempt from Medicaid Payability Assessment in the NY EMA
   Services provided under the following service categories are never considered to be payable by Medicaid:
   a. Early Intervention Services
   b. Food and Nutrition
   c. Housing Services (including short-term housing, housing placement assistance, and short-term rental assistance)
   d. Legal Services
   e. Non-Medicaid Case Management for Currently Incarcerated or Recently Released Individuals
   f. Psychosocial Support Services- Tri-County
   g. Supportive Counseling

2. Service Categories with Medicaid Payable Services
   The following service categories include services that may be payable by Medicaid. Service units submitted for payment under the subaward agreement will be subject to a Medicaid payability assessment:
   a. Medical Case Management (referred to as Care Coordination in NYC and Medical Case Management in Tri-County)
   b. Substance Abuse Outpatient Care (referred to as Harm Reduction Services in NYC)
   c. Medical Transportation in Tri-County
   d. Mental Health Services in NYC and Tri-County
   e. Oral Health Care in NYC and Tri-County
   f. Outpatient/Ambulatory Health Services (referred to as Outpatient Ambulatory Health Services for Aging People with HIV in NYC)

[23]Public Health Solutions, "Addendum 2, Payor of Last Resort Assessment", (2023), pg. 1

Core Medical Services	Support Services
AIDS Drug Assistance Program Treatments*	Child Care Services
AIDS Pharmaceutical Assistance	Emergency Financial Assistance*
Early Intervention Services*	Food Bank/Home Delivered Meals*
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals	Health Education/Risk Reduction*
Home and Community-Based Health Services	Housing*
Home Health Care	Linguistic Services
Hospice	Medical Transportation*
Medical Case Management, Including Treatment-Adherence Services*	Non-Medical Case Management Services*
Medical Nutrition Therapy	Other Professional Services*
Mental Health Services*	Outreach Services
Oral Health Care*	Psychosocial Support Services*
Outpatient/Ambulatory Health Services*	Referral for Health Care and Support Services
Substance Abuse Outpatient Care*	Rehabilitation Services
	Respite Care
	Substance Abuse Services (Residential)

Table 1. Core Medical Services and Support Services for RWHAP Part A

**RWHAP Part A services funded in the NY EMA. Please note that some services are only available in the NYC five boroughs or the Lower Hudson Valley/Tri-County region of the EMA. A complete list of RWHAP Part A services available in the NY EMA and their locations can be found on the nyc.gov website for Ryan White.*

3.4 Allowable use of funds PCN 16-02

PCN 16-02 defines and provides program guidance for each of the core medical and support services listed in the table in section 3.3 and defines individuals who are eligible to receive these HRSA RWHAP Part A services. This PCN replaces the HRSA HIV/AIDS Bureau (HAB) PCN 10-02: Eligible Individuals & Allowable Uses of Funds.

Allowable Costs

The core medical and support service categories listed in Table 1 of Section 3.3 are allowable uses of HRSA RWHAP Part A funds. The HRSA RWHAP Part A Recipient, along with respective planning bodies, will make the final decision regarding the specific services to be funded under their grant or cooperative agreement in the NY EMA. For a description of each RWHAP Part A service category, please refer to the complete PCN 16-02 from HRSA. For details on salary maximum, incentives, special allowable costs (including equipment/vehicle purchases), and out-of-town conference requests, please refer to Sections 4.5, 4.6, and 4.7 respectively.

Unallowable costs

As per PCN 16-02, HRSA RWHAP Part A funds cannot be used to make cash payments to intended clients. This prohibition includes cash incentives and cash intended as payment for HRSA RWHAP Part A core medical and support services. Additionally, it does not allow currently enrolled RWHAP Part A clients to be hired as peer workers. Where direct provision of the service is not possible or effective, please refer to section 4.6 General Incentives (and Section 4.7 Special Allowable Costs, if applicable) for alternative necessary and reasonable spending. HRSA RWHAP Part A recipients are advised to administer incentives in a manner which assures that the incentives cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for the disbursed incentives.

Other unallowable costs include:

1. Clothing
2. Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)
3. Funeral and Burial Expenses
4. Property Taxes

5. Pre-Exposure Prophylaxis (PrEP)
6. Non-occupational Post-Exposure Prophylaxis (nPEP)
7. Materials designed to promote or directly encourage intravenous drug use or sexual activity
8. International travel
9. The purchase or improvement of land
10. The purchase, construction, or permanent improvement of any building or other facility.
11. Small Household Appliances

AIDS Drug Assistance Program

The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA) approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral (ART) therapy, with prior approval.

Eligible Affected Individuals (People Not Identified with HIV)

The principal intent of the RWHAP Part A statute is to provide services to PWH, including those whose illness has progressed to the point of clinically-defined AIDS. When setting and implementing priorities for the allocation of funds, recipients, Part A Planning Councils, and community planning bodies may optionally define eligibility for certain services more precisely, but they may NOT broaden the definition of who is eligible for services (refer to section 3.2 for the HRSA-defined RWHAP Part A eligibility requirements). HRSA HAB expects all HRSA RWHAP recipients to establish and monitor procedures to ensure that all funded providers verify and document client eligibility.

Affected individuals (people not identified with HIV) may be eligible for HRSA RWHAP Part A services in limited situations, but these services for affected individuals must always benefit PWH. Funds awarded under the HRSA RWHAP Part A may be used for services for affected individuals only in the circumstances described below:

1. The primary purpose of the service is to enable the affected individual to participate in the care of a PWH. Examples include caregiver training for in-home medical or support services; psychosocial support services, such as caregiver support groups; and/or respite care services that assist affected individuals with the stresses of providing daily care for a PWH.
2. The service directly enables PWH to receive needed medical or support services by removing an identified barrier to care. Examples include payment of a HRSA RWHAP Part A client's portion of a family health insurance policy premium to ensure continuity of insurance coverage that client, or childcare for the client's children while they receive HIV-related medical care or support services.
3. The service promotes family stability for coping with the unique challenges posed by HIV. Examples include psychosocial support services—including mental health services funded by RWHAP Part D only—that focus on equipping affected family members and caregivers to manage the stress and loss associated with HIV.
4. Services to affected individuals that meet these criteria may not continue after the death of the family member who was living with HIV.

3.5 Treatment of Costs Under RWHAP Parts A, B, C, D PCN 15-01

Parts A – D of Title XXVI of the Public Health Service Act include a cap that limits the costs of administering the RWHAP Parts A, B, C, or D grant award to 10%. This limitation applies to subrecipients. Administrative costs are defined as the costs incurred for usual and recognized overhead, including established indirect rates for organizations, management and oversight of programs, and other types of program support, such as quality assurance, quality control, and related

activities. Administrative costs include planning, managing, monitoring, and evaluating RWHAP Parts A-D programs.[24][25] PCN 15-01 provides guidance for the treatment of costs under the statutory 10% administrative cap for RWHAP Part A.

The following programmatic costs are not required to be included in the 10% limit on administrative costs, as they may be charged to the relevant service category (as described in HRSA HAB PCN 16-02):

a. Biannual RWHAP client re-certification;
b. The portion of malpractice insurance related to RWHAP clinical care;
c. The portion of fees and services for electronic medical records maintenance, technology licensure, and annual updates, as well as staff time for data entry related to RWHAP clinical care and support services;
d. The portion of the clinic receptionist's time providing direct RWHAP patient services (e.g., scheduling appointments and other intake activities);
e. The portion of medical waste removal and linen services related to the provision of RWHAP services;
f. The portion of medical billing staff related to RWHAP services; and
g. The portion of a supervisor's time devoted to providing professional oversight and direction regarding RWHAP-funded core medical or support service activities—sufficient to assure the delivery of appropriate and high-quality HIV care—to clinicians, case managers, and other individuals providing services to RWHAP clients (would not include general administrative supervision of these individuals).

Subrecipients must adhere to the 10% administrative cap requirements. Subrecipient administrative expenses may be individually set and may vary; however, the aggregate total of subrecipients' administrative costs may not exceed the 10% limit.

3.6 Clinical Quality Management (PCN 15-02)

PCN 15-02 details RWHAP Part A expectations for CQM programs. A CQM program is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction. The complexity of HIV care and the RWHAP commitment to equal access to high-quality care for all PWH require systematic efforts to ensure all RWHAP-funded services are delivered efficiently and effectively. The legislation specifically requires RWHAP Parts A-D recipients to establish a CQM program to:

1. Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines (otherwise known as the HHS guidelines) for the treatment of HIV and related opportunistic infections; and
2. Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

RWHAP Part A CQM programs should use effective and proven quality management concepts and quality improvement methods in program development and implementation. The recipient works directly with their subrecipients to provide overall direction and to implement, monitor, and exchange any needed data for performance measures and/or QI activities.

Role of Performance Measurement

Performance measurement is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes on an individual or population level, and patient satisfaction. In order to appropriately assess outcomes, measurement must occur. The recipient is responsible for identifying and analyzing the measures to assess quality of care, health disparities, and inform quality improvement activities.

[24] JSI Research and Training Institute et al., "Ryan White HIV/AIDS Program Part A Planning Council Primer" (June 2018), pg. 9, https://targethiv.org/sites/default/files/file-upload/resources/Primer_June2018.pdf.
[25] Program Part A Manual" (Manual, Division of Metropolitan HIV/AIDS Programs, March 2023), pg. 56, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf.

Quality Improvement (QI)[26]

QI is a process of analyzing performance measure data and implementing activities to improve performance. Similar to performance measures, QI activities must focus on improving patient care, health outcomes, and/or client satisfaction. QI must be implemented using a defined methodology and done in an organized systematic fashion (e.g., by using the Model for Improvement, Lean Six Sigma, etc.).

The NY EMA QMPI team supports the delivery of responsive, evidence-based, and high-quality HIV services. The program is committed to improving the quality of care and services for PWH through collaboration with service providers and consumers, capacity building opportunities, continuous quality improvement activities, and performance measurement. Through these efforts, CQM is not a task performed to fulfill an obligation but rather an approach that is integrated into standard program activities.[27]

Internal Quality Management/Improvement Methods: Each subrecipient should develop and implement quality management processes to ensure consistency and accuracy of data collection, service delivery, and data reporting as part of ensuring quality of services delivered/reported. As part of quality management, subrecipients should review records regularly—at a minimum, quarterly—and must have systems in place to incorporate these reviews and other QI methods into the program improvement process.

3.7 NY EMA Data System for Performance Measurement

The Electronic System for HIV Reporting and Evaluation (eSHARE) is a data reporting system managed by the NYC Health Department that collects information from subrecipients delivering HIV prevention, care, and treatment based on services. RWHAP Part A-funded services are reported through eSHARE, as it provides a unified information system that allows data to be available in real time and accessible by all stakeholders.

Use of Data: eSHARE data include client-level sociodemographic, psychosocial and health outcomes information, and service utilization information. In support of national goals, these data—particularly when merged with comprehensive laboratory data from HIV surveillance—enable the NY EMA to evaluate a range of disparities in care, including those related to race and ethnicity, gender, age, transmission risk category, and geographic location, among other factors. eSHARE is the only population-level source of data on psychosocial, structural, and behavioral needs and barriers to service among RWHAP Part A clients in the NY EMA.

Timely data entry into eSHARE allows for accurate reflection of service delivery, payment, and analysis of service utilization. Data entered into eSHARE also assists in processing payments or services delivered by subrecipients. Timely data entry into the system allows for accurate reflection of service delivery, reimbursement, and analysis of service utilization. Subrecipients are required to enter all services delivered for their RWHAP Part A contract and are strongly encouraged to have a standardized process for data entry and maintenance. **All data on service delivery is due for each month by the 15th.** In addition, each subrecipient must designate one to two individuals as centralized eSHARE Administrators to manage all contracts funded by the NYC Health Department.

Tools & Resources for eSHARE: Specific training and resources on eSHARE for subrecipients are available via the eSHARE Technical Assistance Unit and the QMPI Unit, as well as on the eSHARE website. The QMPI unit is also available to assist subrecipients with developing processes to ensure quality data entry and service reporting. Subrecipients should utilize the following tools to assist with eSHARE data entry:

- Materials
  - eSHARE Mapping (note that specific versions exist for each service category)
  - eSHARE Data Entry Guide
  - Services Tracking Log (STL)

[26] Program Part A Manual" (Manual, Division of Metropolitan HIV/AIDS Programs, March 2023), pg. 46, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf.
[27] NYC Health Department, Care and Treatment Program, Quality Management and Program Implementation Unit, "NY EMA QM Plan for 2023-2026" (2023).

- Trainings
  - eSHARE End User Training
  - eSHARE Administrator Training
    eSHARE Canned Reports Training

Section 4: Fiscal Management

The guidance and policies set forth in this section apply to all subrecipients. It is the responsibility of the subrecipient to ensure this information is available to all sub-contractors. The policies are in place to ensure the proper use of RWHAP Part A funds and to guarantee subrecipients are using federal funds adhering to the "Payor of Last Resort" statute. A subrecipient's financial management system must identify, in its accounts, all federal awards received and expended and the federal programs under which they were received (45 CFR § 75.302 (b)(1)). Subrecipient agreements contain a federal award information page.

4.1 Schedule of Charges and Limitations on Charges[28]

The RWHAP Part A legislation requires clients to be charged a fee for RWHAP Part A-funded services when that service normally requires a fee. The legislation also requires charges to be capped when the annual aggregate limit is reached.

1. Subrecipients who are direct service providers must develop a Schedule of Charges based on an eligible client's individual annual gross income that may take the form of a flat rate or a varying rate (e.g. sliding fee scale).
2. While a subrecipient is required to charge a fee, they are NOT required to collect the fee. No client will be denied services due to the inability to pay, and unpaid charges may NOT be turned over to debt collection agencies.

Schedule of Charges Guidance

It is the subrecipient's responsibility to ensure that policies and procedures specify charges to clients for services, which may include a documented decision to impose only a nominal charge in compliance with RWHAP legislation and HRSA guidance. Service provider's policies and procedures must be revised per the Federal Poverty Level guidelines (FPL) within 30 days of its annual update.

Schedule of Charges must be determined using the client's annual income (not the total household or family income). Organizations should decide and establish whether a schedule of charges for clients with incomes over 100% FPL is a flat rate or on a sliding fee scale. Schedule of charges should be made publicly available, and clients should be informed of the placement of schedule of charges. Organizations should inform clients of their cap and the client's responsibility to track all charges. Organizations should stop imposing charges on the client when the cap is met.

The subrecipient shall establish, document, and have available for review:

1. A written imposition of charges policy that includes a schedule of charges;
2. Current schedule of charges that is made publicly available;
3. Client eligibility determination in client records;
4. Responsibility for client eligibility determination to establish individual fees and caps;
5. Fees charged by the provider and the payments made to that provider by clients;
6. Process for obtaining and documenting client charges and payments through an accounting system, manual, or electronic;
7. Tracking of RWHAP Part A charges or medical expenses inclusive of enrollment fees, deductibles, co-payments, etc.;
8. Process to assess, document, and track charges imposed by other RWHAP providers toward a client's cap on charges; and
9. A process for alerting the billing system when the client has reached the cap and should not be further charged for the remainder of the year.

[28] HIV/AIDS Bureau, Division of State HIV/AIDS Programs, "Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients" (June 2022), pg. 92-96, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf.

FPL at or below 100% and Client Charges

No charges are to be imposed on clients with income below 100% of the FPL. Individual annual aggregate charges to patients receiving services must conform to the following limits:

1. In the case of individuals with an income less than or equal to 100% of the official poverty line, the subrecipient will not impose charges on any such individual for the provision of services under the grant;
2. In the case of individuals with an income greater than 100% of the official poverty line, the subrecipient: A) will impose a charge on each such individual for the provision of such services; and B) will impose the charge according to a schedule of charges that is made available to the public.

In addition, a policy must be implemented that limits the charges that can be imposed on a client, in a given year, for RWHAP Part A services based on a percent of the client's annual income relative to the FPL:

1. No charge for clients with incomes less than or equal to 100% of the FPL;
2. Charges may not exceed 5% of annual gross income for clients with incomes between 101% and 200% of the FPL;
3. Charges may not exceed 7% of annual gross income for clients with incomes between 201% and 300% of the FPL; and
4. Charges may not exceed 10% of annual gross income for clients with incomes greater than 300% of FPL.[29]

The subrecipient will document that their policy for the schedule of charges does not allow clients below 100% of the FPL to be charged for services so that personnel are aware of and are consistently following the policy for schedule of charges. The policy for schedule of charges must be publicly posted.[30]

4.2 Fiscal Reporting of Third-Party Funds/Program Income

Program income means gross income earned by the recipient or subrecipient that is directly generated by a supported activity or earned as a result of the federal award during the period of performance.[31] Program income is most commonly generated by recipients and subrecipients as a result of charging for services and receiving payment from third-party reimbursement. There are two instances where RWHAP Part A-funded subrecipients might generate program income: 1) back-billing for Medicaid or insurance-eligible services when services were provided before insurance or Medicaid were activated; and 2) income from co-payments and charges to patients for providing services. This is to provide clarification to subrecipients regarding the use and reporting of program income as it relates to funds awarded through the RWHAP.

Use of Program Income

HRSA's HIV/AIDS Bureau (HAB) is authorized to consider how program income is to be used and is authorized to make a distinction between income earned by the recipient and income earned by subrecipients. HAB has determined that the use of program income is additive, not deductive; that means that accruing and accurately reporting program income will not affect the funding amount of future awards. Program income must be used for the purposes for which the award was made and may only be used for allowable costs under the award. Program income must be reinvested back into the RWHAP Part A program for services to those who are eligible. This may include any HRSA-defined RWHAP service category, whether a program was funded for that category by the NYC Health Department or not (e.g., a medical case management contractor may use program income for HRSA-defined home delivered meals). HRSA-defined service categories may be found in sections B and C of the RWHAP Part A monitoring standards.[32]

Under RWHAP Part A, allowable costs are those limited to core medical and support services, clinical quality management, and administrative expenses (including planning and evaluation), as part of a comprehensive system of care for low-income individuals living with HIV.

[29] HIV/AIDS Bureau, Division of State HIV/AIDS Programs, "Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients" (June 2022), pg. 94-95, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf.4

[30] HIV/AIDS Bureau, Division of State HIV/AIDS Programs, "Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients" (June 2022), pg. 92-95, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf.

[31] HIV/AIDS Bureau, Division of State HIV/AIDS Programs, "Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients" (June 2022), pg. 92-96, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf.

[32] HIV/AIDS Bureau, Division of State HIV/AIDS Programs, "Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients" (June 2022), pg. 86, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf.

Program income may be utilized for elements of the program that are otherwise limited by statutory provisions, such as administrative and clinical quality management activities that might exceed statutory caps or unique services that are needed to maintain a comprehensive program approach but that would still be considered allowable under the award. Under the uniform administrative requirements, to the extent available, recipients and subrecipients must disburse funds available from program income before requesting additional cash payments.[33] Subrecipients should strive to proactively secure and estimate the extent to which program income will be accrued. This should be done to effectively determine the need for RWHAP Part A funds and their allocation and utilization during the current period of performance.

Types of Income That Are Not Considered Program Income

Except as otherwise provided in Federal statutes, regulations, or the terms and conditions of the Federal award, program income does not include rebates, credits, discounts, and interest earned on any of them.[34] Specific examples include:

1. Other Federal (including RWHAP) grants awards or subawards;
2. Interest earned on advances of Federal funds; and
3. Refunds for overpayments for goods and services or the return of a product. (To the extent that refunds relate to allowable costs, they must be credited to the RWHAP award either as a cost reduction or a cash refund, as appropriate.)

Reporting Program Income from RWHAP Part A Housing

For RWHAP Part A housing programs, program income includes payments for client rent made by the New York City HIV/AIDS Services Administration (HASA), Public Assistance (PA), and fees for usage and occupancy paid by the program client; program income must be reported monthly by the RWHAP Part A housing subrecipients. Housing subrecipients must utilize the *Free Resident Rent Calculator* when calculating the total payment made by the program client for usage and occupancy of the unit. The *Free Resident Rent Calculator* can be found at https://freerentcalculator.com/index.cfm.

RWHAP Part A-funded subrecipients are required to establish proper accounting methods to ensure program income is being tracked as a restricted revenue source and is used for eligible and approved RWHAP Part A project activities. See the below examples that detail the tracking and use of program income:

Example 1 – Congregate Resident Fee for Usage and Occupancy: Subrecipient A operates a 35-unit congregate housing program funded by RWHAP Part A funds. Program clients enter into a tenancy agreement with Subrecipient A. John Smith resides in one of the housing units. The rent for the housing unit occupied by Mr. Smith is $850. Mr. Smith solely receives income from HASA. After calculating Mr. Smith's fee for usage and occupancy the Free Rent Calculator, he would have a monthly payment of $0.00 because he solely receives income from HASA, which is a form of public assistance, and is therefore not included when calculating his contribution amount towards tenant rental payment. On a monthly basis, Organization A receives $850 from HASA for the housing unit that is currently being occupied by Mr. Smith. The $850 collected from HASA must be recorded and tracked by Subrecipient A as restricted revenue. These restricted funds must then be used by Subrecipient A to fund RWHAP Part A eligible activities, such as operations and maintenance of the congregate housing facility.

Example 2 – Scattered-Site Resident Fee for Usage and Occupancy: Subrecipient B operates a 30-unit, scattered-site housing program funded by RWHAP Part A funds. All 30 units are leased by Subrecipient B. Program clients enter into a tenancy agreement with Organization B. Janet Brown resides in one of the scattered-site apartment units. Ms. Brown currently receives $808 from Supplemental Security Income (SSI) and her fees for usage and occupancy equals $232.40. On a monthly basis, Subrecipient B collects the $232.40 from Ms. Brown. The $232.40 collected from Ms. Brown must be

[33] HIV/AIDS Bureau, Division of State HIV/AIDS Programs, "Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients" (June 2022), pg. 89, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf.
[34] HIV/AIDS Bureau, Division of State HIV/AIDS Programs, "Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients" (June 2022), pg. 91, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf.

recorded by Subrecipient B as restricted revenue. These restricted funds must then be used by Subrecipient B to cover a share of the monthly apartment rent paid to the landlord.

Tracking Program Income

To track program income, subrecipients need a tracking system to quantify how much is earned from third-party insurance in the "back-billing" period once a client's insurance application has been approved. It should also stop any billing to RWHAP Part A once insurance is in place. Once a tracking system is in place, the following must be done:

1. Query other billing/reporting systems to determine income received for services from date of enrollment up to the successful enrollment in insurance program.
2. Calculate the aggregate amount of income generated (i.e., collected) and costs covered by the program income and report to PHS at closeout.
3. Ensure that program income is used to expand program services or to cover allowable costs not paid for by contract income (not subject to a cap on administrative costs).
4. Separately track costs associated with subaward federal income and program income.

For all RWHAP Part A subawards, subrecipients must report aggregate cumulative program income information during closeout. RWHAP Part A housing programs must also report program income on a monthly basis (in addition to contract closeout). PHS will require an attestation that program income was used in accordance with applicable costs restrictions.

When the RWHAP Part A grant is the federal award that makes a recipient eligible as a 340B Drug Pricing Program covered entity, and the recipient purchases pharmaceuticals via 340B pricing, the program income should be attributed to the RWHAP Part A grant. When a recipient is 340B-eligible and purchases pharmaceuticals via 340B pricing under multiple awards, the recipient must use a reasonable allocation method for the attribution of costs and program income and be able to document the methodology used.

4.3 Appropriate Assignment of Ryan White Administrative Costs

All incurred expenses by RWHAP Part A subrecipients are considered either program costs or administrative costs. In addition, administrative costs can be classified as either direct or indirect, while all program costs are direct.

Program Costs**:** Program costs are defined as costs incurred for direct service delivery. These costs are generally incurred as a direct result of providing a specific service to a client or a member of the client's family.

1. *Direct Program Costs:* Direct program costs contain 0% administrative costs, as they are considered service delivery costs. Direct program cost examples include, but are not limited to:
   a. Providing direct services funded via the contract (primary and back-up);
   b. Salaries and related fringe benefits for staff who provide direct services to clients, their clinical supervisors, and other staff who directly support these individuals;
   c. Salaries and related fringe benefits of staff who enter client level data and who document all data needed for the provision of services, client follow-up and health status monitoring;
   d. Consultants who provide direct services to clients, supervise program staff, develop program materials, or perform other program functions;
   e. Program supplies such as educational materials, medical supplies, and other supplies that are specifically used for the program;
   f. Office supplies, such as folders for client charts, that directly support program activities
   g. Travel costs for program clients and program staff providing direct services;
   h. Printing and photocopying of medical forms, program materials, and other materials used by or for program participants;
   i. Equipment used for direct service delivery; and
   j. The portion of malpractice insurance for all licensed practitioners related to clinical care.

2. *Non-Direct Program Costs:* Non-direct program costs are required programmatic activities but not necessarily discrete services. Non-direct program costs are programmatic activities that contain 0% administrative costs. Non-direct program cost examples include, but are not limited to:
   a. Determining if referrals to clients were made correctly;
   b. Determining if services were provided per service model and/or protocol;
   c. Conducting service documentation review for adherence to program model;
   d. Determining if client flow is appropriate;
   e. Directly observing service delivery to ensure adherence to program model;
   f. Conducting supervisory review of service plan and progress notes;
   g. Participation in case-conference meetings to coordinate client care;
   h. Entering client service information in the reporting system for the purposes of quality management (note: as data entry into eSHARE is a mix of reporting and quality management, most data entry salaries should be a mix of admin and direct program);
   i. Travel costs not related to service provision, with approval by NYC Health Department and PHS;
   j. Engaging in learning network meetings;
   k. Participation in NYC Health Department provider meetings;
   l. Engaging with NYC Health Department Project Officers in program assessment and technical assistance;
   m. Participation in program evaluation activities as required by the Scope of Services;
   n. Obtaining Primary Care Status Measures (PCSM) information from the client and/or providers and documenting them in the client record;
   o. Reviewing charts to determine need for PCSM follow-up;
   p. The portion of a supervisor's time devoted to providing professional oversight and direction regarding core medical or support service activities (does not include general administrative supervision of these individuals);
   q. Providing clinical supervision to direct-service provider staff;
   r. Providing clinical supervision to non-service provider staff related to service; and
   s. Attending various training as required by the Scope of Services.

Administrative Costs: Administrative costs (defined in section 3.5 of this manual) can be **direct** or **indirect costs** incurred and combined must not exceed the 10% administrative cap described in PCN 15-01.

1. *Direct Costs:* Direct costs that are administrative are costs that can be directly charged to the program and are incurred in the provision of direct services and have an administrative percent. Examples of direct costs (with a portion/percentage that is administrative):
   a. Salaries and related fringe benefits for staff based on actual time worked, and charges are applied to the program or project for which they work;
   b. Expenses related to above-indicated staff, including recruitment costs and travel expenses;
   c. Telephone expenses related to a unique telephone number or an extension for which expenses can be determined and substantiated on an actual or allocated basis;
   d. Space costs and related expenses for facility space that is used only for funded activities, for which expenses can be determined and substantiated on an actual or allocated basis;
   e. All program supplies, as defined above; and
   f. Other expenses that are both directly attributable to the program and consistently treated, on an organization-wide basis, as direct costs.

2. *Indirect Costs:* Indirect costs are considered costs which are incurred for common or joint activities that cannot be identified specifically with a project or program and are 100% administrative. Examples of indirect costs:
   a. Salaries and related fringe benefits for staff who do not charge their time directly to specific individual programs and/or projects, either because of the nature of the position or because it is not realistic to allocate their salaries, on the basis of actual time worked, to numerous programs or projects funded by multiple sources;
   b. Expenses related to staff who are indirectly charged, including recruitment costs and travel expenses;
   c. Telephone costs and space usage that is not designated solely to the program, for which actual expense cannot be determined and/or substantiated;

d. Other expenses that are not specifically identified with the program; and
e. All insurance coverage (including, but not limited to, liability, auto, property, professional, directors and officers) is 100% administrative, except for the portion of malpractice insurance for all licensed practitioners related to clinical care. Note: malpractice insurance for the clinic or facility is considered 100% administrative.

All indirect costs are normally pooled to create an indirect cost rate which is then applied to individual grant and contract-supported projects. Documentation of indirect costs is contained in the contractor's budget submission and other documents submitted to PHS.

4.4 Negotiated Indirect Cost Rate (NICRA)

Inclusion of the 10% cap Indirect Cost by Using Negotiated Cost Rate

Inclusion of indirect costs under a federal award are applicable only where the contractor has a HHS Negotiated Indirect Cost Rate (NICRA) using the Certification of Cost Allocation Plan or Certificate of Indirect Costs, which has been reviewed by HHS. *Note: To obtain an indirect cost rate through HHS's Division of Cost Allocation (DCA), visit their website at* Indirect Cost Negotiations | HHS.gov.

De Minimis Rate

Organizations using a de minimis rate can budget up to 10% of the modified total direct cost (total budgeted direct costs excluding equipment and direct budgeted administrative costs) as indirect costs. Only organizations that have never had a NICRA can use the de Minimis rate. De minimis rate is subject to change in accordance with federal Office of Management and Budget (OMB) uniform guidance and pending HRSA approval.

The rate methodology must be used consistently across all federal grants (i.e., if you budget an item as a direct administrative or program cost on one grant, you cannot include it as part of your indirect costs on another grant). Organizations must document how they arrived at the modified direct cost and have it available for review upon request. Documentation of the indirect cost rate is contained in the contractor's approved budget submission and other documents submitted to PHS.

4.5 Limitations on the Use of RWHAP Part A Funds – Salary Maximum[35]

HRSA funds may not be used to pay the salary of an individual at a rate in excess of the current salary rate for a federal Executive Level II[36]. Please check the HRSA website for information regarding the current salary cap, as this amount gets updated annually. This amount reflects an individual's base salary, exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization.

For subrecipients to comply with the salary maximum, they must:

1. Monitor staff salaries to determine whether the salary limit is being exceeded;
2. Monitor prorated salaries to ensure that the salary when calculated at 100% does not exceed the HRSA salary limit;
3. Monitor staff salaries to determine that the salary limit is not exceeded when the aggregate salary funding from other federal sources including all parts of RWHAP do not exceed the limitation; and
4. Review payroll reports, payroll allocation journals, and employee contracts.

In addition, subrecipients cannot submit budgets with RWHAP Part A-funded salary in excess of the capped amount, regardless of their FTE (full time equivalent). Subrecipients must pro-rate the capped amount on their budgets. For example, if a staff salary is $200,000 annually and the actual FTE is 0.50, then the requested amount would be $100,000. However, in the budget submitted to PHS, contractors must use the salary cap amount. For this example, the salary cap will be set at $212,100 (but please defer to the salary cap listed on the HRSA website). The actual FTE for the staff

[35] HIV/AIDS Bureau, Division of State HIV/AIDS Programs, "Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients" (June 2022), pg. 143, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part.pdf.

[36] HRSA Office of Federal Assistance Management (OFAM), "Grants Policy Bulletin Legislative Mandates in Grants Management for FY 2023 (2023-02E)" (HRSA, February 21, 2023), https://www.hrsa.gov/sites/default/files/hrsa/grants/manage/legislative-mandates-grants-management-2023.pdf

member is still 0.50, and the requested amount is $106,050. Refer to these instructions and guidance for additional information regarding salary caps.

If a staff member's salary budget line appears across multiple budgets, prior to submission the subrecipient must ensure that salary amounts are the same across these budgets and that the FTE across these budgets does not add up to more than 1.0.

Subrecipients must calculate the fringe rate based on the total requested salary amount. Documentation of staff salaries is contained in the subrecipient agreement holder approved budget submission and other documents submitted to PHS.

4.6 General Incentives

Subrecipients may request to use incentives in their RWHAP Part A programs by completing the Incentives Request Form available from their PHS contract manager. Before completing the form, organizations should read the *Policy on the Use of Incentives in Ryan White Part A Programs in the NY EMA* thoroughly. The policy includes service category-specific information on the use of incentives. Subrecipients may submit the request form to PHS and the Recipient by email.

According to the HHS, "incentive payments to individuals to motivate them to take advantage of grant-supported health care or other services are allowable if within the scope of an approved project."[37] This means incentives must be tied to the activities and outcomes associated with the contracted RWHAP Part A activities. Incentives may not be requested for activities outside the scope of a RWHAP Part A contract. This policy refers only to the use of incentives purchased with RWHAP Part A funds or with program income derived from RWHAP Part A-funded activities.

As a steward of public funds, the NYC Health Department sets incentive policy by service category, which is used by PHS to determine whether incentive requests will be approved. To this end, the NYC Health Department limits the use of incentives in all service categories. Permission to use incentives must be received prior to the first use of incentives and anytime there are changes to the scope of their use (e.g., significant changes to service levels or changes to gift card type/value).

Incentive request amounts must be consistent with the service levels and targets in the current contract. Incentives may not be in the form of cash payments to clients. Gift cards are an acceptable incentive but must not be redeemable for cash and may not be in the form of pre-paid credit cards. According to HRSA policy, gift cards may not be used to purchase tobacco, alcohol, illegal drugs, or firearms. Subrecipients must create a sticker that lists these prohibitions and affix it to the front of the gift cards. Only the following gift cards are acceptable:

1. Grocery stores;
2. Pharmacies;
3. Discount retail stores, such as Kmart or Target, that have household items as well as a pharmacy (note: must have a pharmacy to be considered);
4. Amazon;
5. Phone cards; and
6. Metropolitan Transportation Authority (MTA) Metro and One Metro New York (OMNY) cards.

The following items are unallowable costs and may not be used as incentives: household appliances, pet food, gym memberships or social/recreational activities (e.g., tickets to movies or events).

Hygiene kits that include items such as shampoo and soap—which are utilized as an approved and budgeted component of a program's service model—are considered program supplies, not incentives. Subrecipients must have established policies and procedures for ensuring that incentives are secured, tracked, and distributed appropriately to prevent loss or theft.

[37] U.S. Department of Health and Human Services, "HHS Grants Policy Statement," January 1, 2007, pg. II-34, https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf

Before clients receive an incentive, they must sign a document certifying that they completed the activities necessary to receive the incentive and will not use the gift card to purchase prohibited items.

RWHAP Part A funds cannot be used to purchase meals, except where they are a component of the approved service delivery model. Health and Human Services (HHS) permits reasonable food costs associated with advisory board meetings as an administrative cost. In all other instances, nutritious snacks of negligible value (no more than $3.50 per client) may be considered program supplies. Documentation is contained in the contractor's approved budget submission and other documents submitted to PHS.

Male condoms and internal condoms (also known as FC2) are unallowable incentive costs pursuant to the New York City Health Department.

4.7 Special Allowable Costs

Equipment and Vehicle Purchases

The recipient and HRSA must approve equipment requests with a unit value of $5,000 or more prior to incurring costs. The request can be included in the budget prior to approval; however, the budget must include the following language: "HRSA approval required prior to incurring costs". Equipment with a unit value of less than $5,000 does not require NYC Health Department, HRSA approval, or "approval pending" language in the budget.

All vehicle purchases, regardless of costs, require NYC Health Department and HRSA approval. The request can be included in the budget prior to approval; however, the budget must include the following language: "HRSA approval required prior to incurring costs". Vehicle leases, regardless of costs, do not require NYC Health Department and/or HRSA approval; they do not need "approval pending" language in the budget.

Out-of-State Conferences/Training and Travel

RWHAP Part A funds may be used for expenses directly related to local and national conferences, providing the conference focus is directly related to the funded service category. RWHAP Part A programs must follow HRSA policy. Funds awarded under RWHAP Part A may not be used to pay for professional licensure. Allowable expenses include, but are not limited to registration, lodging, transportation, and per diem allowance. Funds may be used for costs associated with HRSA-sponsored conferences or service-specific training. Refer to Government Services Administration (GSA) website for lodging and M&IE rate limitations.

The Recipient, in conjunction with PHS, will review and approve each request on a case-by-case basis. For any out-of-state conference or training requests, please reach out to your PHS contract manager at least two (2) months prior to the conference date. Requests submitted less than two months prior to the conference data may not be approved.

"Out-of-Town Conference" requests may be entered as a line item in the organization budget prior to submitting the request for approval; however, the organization will need to obtain NYC Health Department approval prior to incurring the cost. If the request is to be listed in the budget, the following justification language must be present: "Pending Approval: Written approval from PHS must be provided prior to spending for this budget item". International travel is unallowable per PCN 16-02.

Staff Qualifications/Credential Exemptions

In accordance with PCN 16-02, to be an allowable cost under the RWHAP program, all services must relate to HIV diagnosis, care, and support and must adhere to established HIV clinical practice standards consistent with HHS treatment guidelines. In addition, all providers must be appropriately licensed and in compliance with state and local regulations, as applicable. At the service category and/or contract level, staff qualification requirements (when applicable) are stated in the contract scope of services (per service type). Other specific qualification requirements may be required per service type by the contract. Contractors may seek an exemption, if necessary. Exemptions can only be requested if the minimum qualification requirement relates to expectations designed by the NYC Health Department. If a qualification or credential relates to licensure and/or professional standards of service delivery—for example, mental health counseling—exceptions cannot be requested or granted.

4.8 Expense and Exception Request Procedures

Certain RWHAP Part A costs (exceptions to policy or special allowable costs) require contractors to follow specific procedures when requesting the expense. The following is the general procedure for requests and is not limited solely to costs contained in this guide.

Request Procedures

If a subrecipient wishes to request a special allowable cost or exception, they must submit a formal request to PHS. If the request is regarding staff qualifications or credentials, contractors must ensure to justify why they are requesting replacing the required staff with another staff member.

Note that for requests for Equipment/Vehicle and Out-of-State Conference Travel and Training, subrecipients must make the request at least two months prior to when they want to make the purchase, in addition to completing and submitting a special form. Additionally, equipment requests may need to be forwarded to HRSA for their approval, specifically when the equipment (including vehicles) costs more than $5,000, as per the NMS.

PHS staff reviews each request and sends it to the NYC Health Department (and possibly HRSA, for equipment requests) for final approval within three to five business days of receipt. Within two days of the NYC Health Department's final decision, PHS sends the contractor the final disposition of the request and updates the tracking system. If the request is approved, PHS updates the contractor's Scope of Services and Budget, as necessary. All documentation is contained in the contractors file at PHS.

Incentives Request

If a subrecipient wishes to request a client incentive, they must submit a formal request to PHS to review each request and evaluate the request against the incentives policy to determine approval. Within 15 business days, PHS will send the subrecipient the final disposition of the request and update the tracking system. Approved requests will be updated in the contractor's Scope of Services and Budget, as necessary. Payments, regardless or payment structure, are contingent upon the submission of all relevant documentation as conditions listed on their signed RWHAP Part A agreement guidelines (i.e. expense reports, vouchers, narrative reports, deliverable support documentation).

4.9 Subrecipient Agreement Payment Structures

Depending on the service category, payment is either conducted via the following, either directly or in combination (as outlined in the contract scope of work and the PHS boilerplate):

- **Cost-Based Payment**: Payments are made based on expenditures reported in accordance with an approved line-item Budget.
- **Deliverable-Based Payment**: Payments are made based on the completion of deliverables, as identified in a Deliverable Schedule within the subaward agreement.
- **Performance-Based Payment (fixed rate)**: Payments are made based on an established rate per service for each discrete service that is provided and reported, as listed on the Schedule E Service Target Grid, in accordance with the service category payment rules.

4.10 Subrecipient Monitoring and Site Visits[38]

As required by HRSA, recipients must ensure that all RWHAP Part A subrecipients receive an annual site visit, unless a recipient has an approved annual subrecipient site visit exemption from HRSA. The subrecipient is responsible for being responsive to these requests. The purpose of site visits is to closely monitor subrecipient activities and protocols to ensure subrecipient compliance with programmatic and fiscal requirements set forth by the RWHAP Part A legislative authorities and the terms and conditions of their subaward. Site visits might include staff interviews, observation of services, review of client records or charts, a facility tour, and a review of various documentation to validate subrecipient operations are compliant with requirements. Following a site visit, each subrecipient will receive a site visit

[38] Program Part A Manual" (Manual, Division of Metropolitan HIV/AIDS Programs, March 2023), pg. 84-85, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf.

report, including any legislative, regulatory, and/or programmatic non-compliance findings and instructions for developing a corrective action plan (CAP), if necessary, within 45 business days after the site visit. While PHS is responsible for overseeing all subrecipient site visit activities in the NY EMA, it is the responsibility of the Recipient to monitor a CAP to ensure its satisfactory completion.

Section 5: Subrecipient Participation & Reporting Requirements

The following are additional requirements for subrecipients as outlined by the recipient and recommended best practices identified by HRSA:

Maintenance of Client Record and Service Delivery Documentation: eSHARE is for reporting data and is not an electronic medical record system or a patient charting system; therefore, a system for charting patient services must be maintained. The subrecipient must have supporting documentation in the client record/patient chart for any data entered in eSHARE, including progress notes (as applicable). Required minimum documentation standards for services (as applicable) are detailed in the *'Documentation Standards Matrix for RWPA Funded Program'*. The subrecipient is required to ensure support documentation meets NYC Health Department standards, as outlined in the Matrix, and that services are provided under the proper service categorization in the client chart and entered as per the guidance in the Matrix.

Program Implementation & Quality Management Assistance: The subrecipient may be required to participate in additional noted activities, including but not limited to provider meetings, webinars, teleconferences, desk audits, and site visits, as required by NYC Health Department and PHS. Subrecipient must ensure that staff with managerial responsibilities attend provider meetings and site visits (e.g., Program Director, Program Supervisor).

Consumer Satisfaction Survey: Consumer satisfaction surveys, designed by NYC Health Department, may be administered periodically. The subrecipient may be required to participate in administering surveys developed by NYC Health Department. Minimum distribution and response expectations will be communicated by NYC Health Department during the survey implementation process.

6.1 Subrecipient Reporting Requirements

Table 2. Grants Reporting Requirements

Subrecipient Requirement	Definition & Method of Submission
Program Narrative Report (ePNR)	Submit a monthly Electronic Program Narrative Report (ePNR) on the PHS report portal describing barriers, issues, and successes experienced during the specified time frame.
Client and Service Data **(in e-SHARE)**	Submit complete and reconciled data in eSHARE on a monthly basis. For further instruction, please reference PHS boilerplate. *Failure to do so may result in reimbursement delays and/or corrective action.*
Deliverables / Milestones	Deliverables/milestones required for submission each fiscal year. These may vary depending on requirements from HRSA and/or revisions to funding allocations approved by the PC. Required documentation, including vouchers, must be emailed to PHS Contract Manager as outlined in the Schedule D.
Ryan White Services Report (RSR)	The RSR collects information on subrecipients and clients served by the RWHAP Part A (excluding ADAP) each fiscal year. Subrecipients must complete and submit the RSR by the required deadline.

Invoices	Subrecipients must adhere to the monthly deadline. *Failure to do so may result in reimbursement delays and/or corrective action. Cost-based contracts only.*

5.2 Available Support

There are a range of services available to support subrecipients conducting this work including:

- Contract Related Support – provided by service category PHS Contract Manager.
- Program Implementation Guidance and Support – provided by service category NYC Health Department Quality Management Specialist.
- e-SHARE Technical Assistance – provided by the NYC Health Department e-SHARE technical specialists.

Subrecipients should not hesitate to reach out to PHS or NYC Health Department point of contacts.

Appendix

I. Resources

HRSA HAB
https://www.hrsa.gov/about/organization/bureaus/hab/index.html

Recipient Resources
https://ryanwhite.hrsa.gov/grants/manage/recipient-resources

Ryan White HIV/AIDS Program Legislation Overview
https://ryanwhite.hrsa.gov/about/legislation

Public Health Service Act Title XXVI—HIV Health Care Services Program
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/about-program/legislation-title-xxvi.pdf

Office of Management and Budget
https://www.whitehouse.gov/omb/

Code of Federal Regulations (CFR) 45
https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/

HHS Grant Policy Statements
https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf

Notice of Funding Opportunity
https://www.hrsa.gov/grants/find-funding

Ryan White HIV/AIDS Part A Manual
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

Ryan White HIV/AIDS Part A National Monitoring Standards
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2023-rwhap-nms-part-a.pdf

HRSA HIV/AIDS Policy Notices
https://ryanwhite.hrsa.gov/grants/policy-notices

HRSA HIV/AIDS Program Letters
https://ryanwhite.hrsa.gov/grants/program-letters

Ryan White HIV/AIDS Program Fact Sheets
https://ryanwhite.hrsa.gov/resources/factsheets

Ryan White HIV/AIDS Minority AIDS Initiative
https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-f-minority-aids-initiative

New York State's Integrated HIV Prevention and Care Plan
https://www.health.ny.gov/diseases/aids/providers/reports/scsn/docs/integrated_hiv_prevention_plan22-26.pdf

CDC/HRSA Integrated HIV Prevention and Care Plan Guidance, CY 2022 - 2026
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/integrated-hiv-dear-college-6-30-21.pdf

Planning Council Primer
https://nyhiv.org/ryan-white-planning-council-primer/

Memorandum of Understanding between the NY Planning Council and the Recipient
https://nyhiv.org/wp-content/uploads/2024/06/Memorandum-of-Agreement_Signed-10-30-23.pdf

Guiding Principles to a Trauma-informed approach
https://stacks.cdc.gov/view/cdc/138924

Planning Council Directives
https://nyhiv.org/our-impact-2/

Framing Directive
https://nyhiv.org/wp-content/uploads/2022/03/Framing-Directive_PC-Approved-12-16-21.pdf

PCN 21-02
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-21-02-determining-eligibility-polr.pdf

PCN 16-02 (Revised 10/22/18)
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf

PCN 15-01
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-01.pdf

PCN 15-02
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-02-cqm.pdf

Federal Poverty Level 2023
https://www.federalregister.gov/documents/2023/01/19/2023-00885/annual-update-of-the-hhs-poverty-guidelines

Ryan White Part A Services for People with HIV in the NY EMA
https://www.nyc.gov/site/doh/health/health-topics/aids-hiv-care-treatment-and-housing.page

NY EMA RWHAP Part A Referral Directory (2024)
https://nyhiv.org/wp-content/uploads/2024/06/NY-EMA-RWPA_Referral-Directory_2024.02.pdf

Target HIV
https://targethiv.org

RWHAP Compass Dashboard
https://ryanwhite.hrsa.gov/data/dashboard

AETC National Coordinating Resource Center
https://aidsetc.org

ADAP Emergency and Service Disruption Preparedness Resource Guide
https://nastad.org/sites/default/files/2022-04/PDF_ADAP_Emergency_Preparedness_Guide_2022_0.pdf

II. Performance Measures for the NY EMA

Performance Measure Definitions

HRSA Service Category	HAB Performance Measure	NY EMA Performance Measure
ADAP Oral Health Mental Health Medical Case Management Substance Abuse Services Food Bank/Home-Delivered Meals Housing Services Medical Transportation Psychosocial Support	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year.	Increase in the percentage of clients who have a suppressed viral load (less than 200 copies/ml) on the most recent viral load measure.
Early Intervention	Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two encounters within the 12-month measurement year.	Among PLWH who know their status, an increase in the percentage successfully linked to HIV/AIDS medical care.
Non-Medical Case Management Health Education/Risk Reduction Legal Services	Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.	Proportion of clients with at least one medical visit in each of three 6-month follow-up periods (at least 60 or 90 days apart from a medical visit in the prior period), among all clients who had a medical visit in the first 6 months of an overall 24-month measurement period.

III. RWHAP Part A Components, Requirements, and Caps

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

Grant Requirements and Caps	
Administrative Costs	Limited to 10% of the award. Includes Planning Council costs as well as indirect costs. Subrecipient administrative costs are capped at 10% in the aggregate.
Clinical Quality Management Costs	CQM program not to exceed 5% of the grant award or $3,000,000, whichever is less.
Salary Rate Limitation	Grant funds may not be used to pay salary rates in excess of the salary of Executive Level II ($212,100 as of January 2023[39]). Please note this subject to change based on federal regulations.

[39] HRSA Office of Federal Assistance Management (OFAM), "Grants Policy Bulletin Legislative Mandates in Grants Management for FY 2023 (2023-02E)" (HRSA, February 21, 2023), https://www.hrsa.gov/sites/default/files/hrsa/grants/manage/legislative-mandates-grants-management-2023.pdf