National Monitoring Standards:

Frequently Asked Questions (FAQs)
Ryan White HIV/AIDS Program Part A and Part B

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National Monitoring Standards Basics

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

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

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

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

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

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

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

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

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

- Code of Federal Regulations (CFR)

- Federal, Department of Health and Human Services (HHS), and Public Health Service grants management policies

- HRSA/HAB policies and guidelines

- Part A and B Program Guidance Documents

- Notices of Award and Conditions of Award *(which accompany the annual grant awards)*

- Office of Inspector General (OIG) reports and recommendations

- Manuals and guides issued by HRSA/HAB (such as the Part A Manual)

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

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

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

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Structure of the National Monitoring Standards Documents

11. **What is the scope of the National Monitoring Standards?**
    There are three sets of standards:

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

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

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

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

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

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

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

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

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

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

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

15. **Are the source documents for the National Monitoring Standards online? The Sources include references to past Part A and Part B Guidances. Past Guidances do not usually remain available. As time passes, where can we find them?**
Yes. Please see the chart in Appendix 1 for the online locations of source documents referenced in the NMS. The National Monitoring Standards reference the most up to date Funding Opportunity Announcement and Guidances. Some of the source documents, including referenced Part A and B Guidances, assurances, and the Ryan White HIV/AIDS Program legislation are posted on the TARGET Center website (www.careacttarget.org). Fiscal documents such as the Code of Federal Regulations can be downloaded from the Government Printing Office at http://ecfr.gpoaccess.gov, and the circulars from the Office of Management and Budget (OMB) at www.whitehouse.gov/omb.

16.
   a. **Will Program Monitoring Standards be developed for Minority AIDS Initiative (MAI)?**
   No, there will be no standards developed for the Minority AIDS Initiative (MAI).

   b. **Do these Monitoring Standards apply to MAI?**
   Yes. Part A and Part B Monitoring Standards apply to MAI funds received as part of Part A and Part B grant awards.

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Implementation of the National Monitoring Standards

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

18. **Are there ongoing expected actions Grantees should take to implement the NMS?**
Yes. Grantees are expected to take the following steps to ensure ongoing implementation of the NMS:

   - Regularly review the NMS that apply to your program. The NMS are updated on a quarterly basis. If some are unfamiliar, go to the citation for more information.
   - Regularly share the NMS and supporting materials with program and fiscal staff that have monitoring responsibilities.
   - Regularly sit down with staff to review current monitoring systems, procedures, and tools to ensure the NMS are already being met and where changes or improvements may be needed.

- Meet regularly with legal, contracts, procurement, finance, and other government entities that have Ryan White HIV/AIDS Program responsibilities and familiarize them with the NMS.
- Decide how grantee and subgrantee responsibilities will be implemented based on the approaches specified in the Monitoring Standards. If you use alternative approaches, be sure they comply with the NMS.
- Review your Requests for Proposals (RFPs) and contract language to ensure they specify that services be provided and data collected and reported in accordance with Ryan White HIV/AIDS Program requirements.
- Ensure the NMS are integrated into your contracting and monitoring efforts and refining those efforts as needed to meet the NMS – changing RFPs, contracts, monitoring tools, site visit schedules and scope, etc., as needed.
- Hold meetings with providers/subgrantees to review the NMS and clarify compliance issues as necessary.
- Make the NMS easily accessible to your providers/subgrantees. Add a link to the NMS on your website and update it as the NMS are updated.
- Fully implement any needed changes in your subgrantee monitoring and oversight policies, procedures and monitoring tools, and in your own fiscal and program management and reporting.
- If you have questions or concerns, contact your Project Officer.

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

20. **Will HRSA make examples of other grantee's monitoring procedures, systems and tools available?**
Yes. We will provide examples of monitoring tools from other Part A and B grantees. Ongoing presentations and webinars will discuss further monitoring systems. In addition, grantees are encouraged to share information, best policies and procedures along with best practices by posting them on the TARGET Center. You may find Part A tools that have been shared under the Grantee Tab here: http://careacttarget.org/monitoringtools.asp
Part B Tools shall be posted in the near future.

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

22. **Are grantees expected to review all client records? What is a recommended sample size?**
No. A random sampling methodology should be established as part of the monitoring protocols. The sample size is not specified in the NMS, because it depends on the size of the client population being sampled and on the number and complexity of the variables you

are reviewing. For a client population of 50 or less, the norm is to review 100% of folders; 50% or less is acceptable for a population of 51-100. The percent to be sampled gets smaller as the population gets larger – from 10% for a client population of 500 or more to 3-5% for a client population of 1000+.

23. **One of HRSA's monitoring expectations is an annual comprehensive site visit to sub-grantees. Is there an exemption?**
Yes. For some grantees the annual site visit requirement has imposed significant challenges. To reduce administrative burden for the Ryan White Part A and Part B Grantees, HRSA/HAB has implemented the "Exemption to Annual Site Visits" through a program letter dated October 4, 2012 This process allows grantees to request an annual site visit exemption through the EHB prior approval process. The request must describe the barriers and challenges precipitating the waiver request and also describe how the program intends to effectively monitor their sub-grantees. .

24. **Are desk audits necessary monthly?**
The usefulness of desk audits and any timelines for their use are determined by the grantee. Desk audits are not addressed in the NMS. Desk audits may not be used as a substitute for comprehensive annual site visits unless approved through an Annual Site Visit Exemption that has been accepted through Prior Approval in EHB.

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

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

27. **Is there an exemption for Part A or B base programs that contribute to the state's ADAP?**
Part A or B base programs that contribute to ADAPs are still accountable for their respective funds. It is HRSA's expectation that the ADAPs and Part A or B base programs work out an agreement to share reporting data. The Part A and B base programs should be able to access data to report on number of clients served using their funds within a given timeframe and geographical location.

28. **Are grantee accounting department's best suited to perform a correct and accurate cost-benefit analysis?**
No. Grantee accounting units can perform cost-benefit analysis **if** they are familiar with Federal Accounting Concepts and Standards on programs related to cost that Federal laws

and regulations impose and with the Ryan White HIV/AIDS Program specific statutory limitations. Outside entities familiar with these concepts, standards, and Ryan White HIV/AIDS Program limitations may also be used.

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Universal Monitoring Standards Questions

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

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

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

31.
    a. **Is the chief elected official (CEO) always the mayor (Part A) or governor (Part B), who in turn designates the local or State health department as the funding recipient?**
       No. The legislation states that for Part B, the funding must go to the State/Territory's chief elected official, who in turn designates a lead agency for the administration and implementation of the program.
    b. **Or, can we have another elected official or funding recipient?**
       Most governors designate the State's health department, which is not universal. Section 2611 of the legislation specifies "The Secretary shall, subject to the

availability of appropriations, make grants to States to enable such States to improve the quality, availability and organization of health care and support services for individuals and families with HIV/AIDS."

For Part A, Section 2602(a) specifies that funding "shall be directed to the chief elected official of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of individuals with AIDS" in the Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA). In some areas, that would be the mayor and in others the county board of supervisors. Again, most but not all Part A CEO's designate their jurisdiction's health department to administer the grant.

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

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

34. **Is there a difference in the documentation required for initial client eligibility requirements and six month client eligibility requirements?**
    Yes. Initial eligibility determination must verify proof of HIV status, proof of residence, and proof of income eligibility based on the income limit (set by the state, EMA/TGA or ADAP), proof of insurance or proof of being underinsured or uninsured. To maintain eligibility clients must be recertified at least every six months to ensure that an individual's residency, income and insurance statuses continue to meet the grantee eligibility requirements and to verify that the Ryan White Program is the payer of last resort. For further clarification, please reference Policy Clarification Notice (PCN) #13-02.

REQUIRED DOCUMENTATION TABLE

	Initial/In-Depth Eligibility Determination	**Recertification(minimum of every six months)**
HIV Status	Documentation required (not required as part of continuation eligibility)	No documentation required
Income	Documentation required	Grantee may choose to require a full application and associated documentation Self-attestation of no change Self-attestation of change - grantee must require documentation
Residency	Documentation required	Grantee may choose to require a full application and associated documentation

		Self-attestation of no change Self-attestation of change - grantee must require documentation
Insurance Status	Grantee must verify if the applicant is enrolled in other health coverage and document status in client file	Grantee must verify if the applicant is enrolled in other health coverage Self-attestation of no change Self-attestation of change - grantee must require documentation
CD4/Viral Load	Discretion of grantee	Discretion of grantee

35. **Is insurance status a client eligibility or payer of last resort issue?**
Insurance status is both an eligibility issue and a payer of last resort compliance issue. Clients must be recertified at a minimum of every 6 months to establish eligibility for Ryan White HIV/AIDS Program services which includes checking for insurance or other third party payers such as Medicaid, Medicare and Medicare Part D. Clients with insurance who are underinsured may continue to be eligible for Ryan White HIV/AIDS Program services.

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

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

38. **Can client eligibility be confirmed by one Ryan White HIV/AIDS Program provider (e.g., case management, primary care) and have this suffice for all Ryan White HIV/AIDS Program programs the client uses, or must every program re-assess eligibility?**
Yes – use of a single eligibility record is acceptable for both Ryan White HIV/AIDS Program Part A and B programs. The following criteria must be satisfied in order to use a single eligibility records: (1) Ryan White HIV/AIDS Program Part A, Base B, C, and ADAP must have the same eligibility criterion that meets the requirements of all the Parts (i.e., use the same percentage of federal poverty limit (FPL) to establish eligibility); (2) there must be an application with supporting documentation (i.e.. income and insurance verification); (3) the application and supporting documentation must be available for review at each of the providers' sites; and (4) the individual provider must be aware that the responsibility of providing allowable services to eligible clients still rests with the individual provider. The sharing of eligibility application and documentation can be done by copying the original application and documents or by electronic access to the application and documentation.

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

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

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

42. **Are clients that become eligible for other funding sources or private insurance still eligible for Ryan White services?**
    Yes. Clients may become eligible for other State programs or private insurance and still be underinsured and qualify for Ryan White services.

43. **Is there a grace/transition period for Ryan White HIV/AIDS Program clients that become eligible for public or private insurance e.g. Medicaid, Medicare/Medicare Part D, private insurance?**
    Ryan White is the payer of last resort and is intended to fill gaps in care. The provider must ensure that funds are not used to provide items or services for which payment already has been made, or reasonably can be expected to be made, by a third party payer. Clients who meet the Part A or B eligibility criteria, have been determined to be eligible for public or private insurance, but for whom the effective date of the coverage is in the future, may still receive Ryan White services during that period up to the effective date. Clients who meet the Part A or B eligibility criteria, have public or private insurance coverage, but for whom a specific service is not covered by the public or private insurance, may still receive that service with Ryan White Program funding. It is the responsibility of the provider to monitor these circumstances.

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

45. **The NMS mention a cap on services. Is this a new requirement?**
    No. Every service has limitations on what services are allowable under that service category, and some may have cost or level of service caps. These limitations are clear

under each service standard, as is the flexibility of the Ryan White HIV/AIDS Program to set Standards of Care that include service caps. There are also financial limitations or caps in the legislation such as: the amount of funding that can be used for administration (10%) or clinical quality management (5%) or in Part B for planning and evaluation (5% or aggregate of 15% for administration and planning). There are also income-based financial limitations on the amount of charges a client can be assessed in a given year before the Ryan White HIV/AIDS Program services are free for the remainder of the year. Service limitations are not a new requirement.

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

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

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

49. **Are we to use the most up to date Federal Poverty Guidelines?**
Yes. The newest Federal Poverty Guidelines should be used.

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Program Monitoring Standards Questions

50. **How should grantees ensure that allowable services are "related to HIV" as in the case of medical services? Where do you draw the line?**
Ryan White HIV/AIDS Program funding for outpatient medical care is clear on what is allowable. The grantee must provide comprehensive, coordinated primary HIV medical care, and this defines the types of office visits that are allowable under Ryan White HIV/AIDS Program. The main characteristic of primary care is that the patients consult their primary care doctor for routine check-ups and any time they have a new physical problem. Consequently, primary care practitioners treat patients seeking to maintain optimal health as well as those with acute and chronic physical, mental, and social health issues, including multiple chronic diseases. Chronic illnesses usually treated by primary care providers include: hypertension, heart failure, angina, diabetes, asthma, COPD, depression, anxiety, back pain, arthritis, thyroid dysfunction, and HIV. Primary care is inclusive of HIV related care and routine primary care unrelated to HIV disease. Where medical specialty care is required, Ryan White HIV/AIDS Program funding is provided only if the condition is related to the individual's HIV disease.

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

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

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

Fiscal Monitoring Standards Questions

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53. **Does HRSA/HAB allow Ryan White HIV/AIDS Part A and B program grantees and providers to allocate a percent of their funding for quality management staff and continuous quality improvement (CQI) activities?**
Yes. However, the Ryan White HIV/AIDS Program legislation limits Part A and B funding for quality management activities to 5% of the total grant award or $3 million, whichever is less. There is no such limitation for Part C or D programs. (See the Ryan White HIV/AIDS Program legislation, Part A, Section 2604(h)(5) and Part B, Section 2618 (b)(3)(E)(i-ii)).

54. **How does a grantee obtain a HRSA-approved indirect cost rate?**

Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may obtain one through HHS's Division of Cost Allocation (DCA). The Division of Cost Allocation in HHS negotiates and approves indirect cost agreements for entities directly receiving funding through the Department. This Division negotiates rates through its four regional field offices and the national headquarters. To obtain information from one of these offices go to: http//rate.psc.gov and click on Contact Information, then click on the appropriate link: National Headquarters, Western, Central States, Mid-Atlantic, Northeastern. Grantees wanting to claim administrative costs in their Ryan White HIV/AIDS Program budget as indirect costs are allowed to do so only (1) with an HHS-approved indirect cost rate in accordance with applicable cost principles; and (2) in accordance with the 10% legislative limitation on administration costs, (i.e., indirect costs are included in the definition of grantee administration under Part A and B, as mandated by the legislation).

55. **What are the indirect cost documentation requirements for the grantee and subgrantees?**
Grantees wanting to claim indirect cost rates in the program budget must have a Negotiated Indirect Cost Rate Agreement with the HHS Division of Cost Allocation. Grantee indirect costs must be applied to the 10% administrative limitation. Subgrantees wanting to claim indirect costs on their budgets are required to submit their established indirect cost rate documentation to the Grantee. Subgrantee indirect costs must be included in the 10% aggregate administration limitation for subgrantees.

56. **Are subcontractor/subgrantee expenses for "rent, utilities etc." an allowable direct service expense?**
No. Subcontractor/subgrantee expenses for rent and utilities are allowable direct and/or indirect ***administrative expenses,*** with certain exceptions noted below. As administrative expenses, these costs are subject to the 10% aggregate limitation imposed by statute... Rent is included in the accounting definition of "overhead". Overhead refers to the ongoing administrative expenses of operating a business (also known as operating expenses – rent, gas/electricity, wages for administrative activities including accounting, supervision, human resources and program administration etc.). Under Ryan White HIV/AIDS Program guidance, subcontractor overhead expenses are considered to be administrative costs.

Exceptions: Under certain, limited circumstances, rent may be an allowable direct service expense:

1. A food bank may charge rent as a direct service in some specific cases. Please work with your HRSA Project Officer to ensure the charge is allowable.
   Examples:
   - pantry which the food is stored
   - location where prepared bags of food may be picked up by the client

2. Residential substance abuse agencies may charge rent as a direct service for the rent of the residential facility for a specific timeframe.
3. Emergency financial assistance or housing services where Ryan White Part A and Part B funds are used to cover all or a portion of a client's rent.

   If you have any questions please refer to the HRSA/HAB letter dated July 17, 2012, or submit an EHB prior approval request to your Project Officer.

57. **Do very large institutions that routinely provide/conduct annual OMB A-133 audits need/require a single point audit of all Ryan White HIV/AIDS -funded programs?**
    Yes. OMB A-133 circular requires a Single Point audit of programs that expend more than $500,000 in aggregate federal funding or are considered to be "high risk". High risk programs are determined based on current and prior audit experience, degree of oversight exercised by the Federal agency and pass-through entities and the inherent risk of in the program. If a program is not a major risk program, the auditor does not have to test samples from the program.

58. **May grantees request a small sub-grant be audited as a major program?**
    Yes. Many Part A and B grantees may have sub-recipients that constitute small sub-grants, which are not considered major programs, and thus HRSA cannot compel that such small sub-grants undergo an audit. However, pursuant to OMB Circular A-133 Section .215 (c), a federal agency or a pass-thru entity may request that a sub-grant be audited as a major program. To accomplish this, the agency or pass-thru entity must give the auditee a notice of 180 days before the fiscal year end, and the agency or pass-thru entity must pay for the audit. As a grantee, you can request that a small sub-grant be audited as a major program with advanced notice and at your own (i.e., charged to the grant) expense. Please refer to HAB/HRSA letter dated September 20, 2012.

59. **Do fiscal monitoring requirements apply to performance-based contracts where the basis of payment is reported services, not expenditures?**
    Yes. Regardless of the type of contract or reimbursement preference, the grantee is mandated to monitor for compliance with Federal requirements and programmatic expectations. In the case of performance-based contracts, the source documentation and selected testing procedures might be different, but the mandate remains the same: to ensure that the delivered service is provided utilizing appropriate cost principles and the amount charged is reasonable. In addition, the Ryan White HIV/AIDS Program is a cost-based reimbursement program, and the grantee is required to perform an annual reconciliation of the amount charged for the service with the actual cost of delivering the service.

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

    - If an individual's income is less than or equal to 100% of the Federal Poverty Level (FPL), the individual may not be charged for services.

    - For individuals with income from 101% to 200% of the FPL, cumulative charges in a calendar year can be no more than 5% of the individual's annual

gross income.

- For individuals with incomes from 201% to 300% of the FPL, cumulative charges in a calendar year can be no more than 7% of the individual's annual gross income.

- For individuals with income over 300% of the FPL, cumulative charges in a calendar year can be no more than 10% of the individual's annual gross income.

- May impose only a nominal charge for services subject to public schedules and limitations on the maximum amount of charges, and taking into consideration the medical expenses of individuals when assessing the amount of the charge.

The legislation explicitly defines and includes as part of "cumulative charges" the charges for HIV-related services performed by providers other than the grantee or its subgrantees. The legislation explicitly refers to enrollment fees, premiums, deductibles, cost sharing, co-payment, coinsurance, or similar charges.

61. **Are schedule of charges and the limitation on annual client charges related?**
Yes. According to the legislation, a schedule of charges is a fee charged to the client based on a publicly posted schedule.

Limitation on annual client charges is the total charges a client can be charged in a given year for HIV services (Ryan White HIV/AIDS Program funded or other), before Ryan White HIV/AIDS Program services are provided free of charge for the remainder of the year.

62. **Is it the grantee's responsibility to track annual client charges from multiple providers?**
No. It is not the responsibility of the grantee to track annual client charges from multiple providers. It is the provider's responsibility to track charges at the respective subgrantee agency.

To meet the legislative requirements on limitation of charges, the providers or subgrantees are required to:

- Verify annual income,

- Determine what a client's cap on charges should be,

- Monitor charges made to clients for all HIV services performed by that provider/subgrantee, whether or not there was a payment, and

- Change the billing status to "no charge" when the cap is reached.

Clients are responsible for saving receipts and bills to document charges for services. It is the responsibility of the grantee to review this documentation to ensure that Ryan White

HIV/AIDS Program clients are not charged more than the legislatively specified cap on charges.

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

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

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

65. **Are some services, for example medical case management, exempted from imposing charges under the sliding fee scale?**
No. The legislative requirement applies to all services for which charges are imposed.

66. **Are discounts based on "schedule of charges" based on individual income?**
Yes. Ryan White HIV/AIDS Program-eligible individuals with individual incomes less than or equal to 100% of the Federal poverty level are not charged or required to pay any optional nominal fees. Individuals with incomes above 100% of the Federal poverty level are charged a discounted rate or a nominal fee so long as the charges do not exceed the limitations based on income mandated by the Ryan White HIV/AIDS Program legislation (limitation on charges).

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

68. **Is reimbursement a form of program income?**
Yes. Program income is derived from an activity or service funded by Ryan White HIV/AIDS Program, such as sliding scale fees or other client cost-sharing payments. Program income remains with the subgrantee; but it must be tracked, added to resources committed to the project or program, and used to further the eligible project or program objectives and/or to cover program costs. Reimbursement refers

to third party payments made by public or private insurance for medical care or other billable services. Reimbursement is a form of program income.

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

70. **Is there a recommended way to establish maintenance of effort (MOE)?**
   Yes. The Part A and B assurances state that "The Maintenance of Effort provision of the legislation requires that grantees maintain year to year HIV related core medical and support service expenditures by political subdivision within the eligible area." The grantee is required to maintain systems that use clear reporting methodologies that consistently track and report grantee MOE expenditures year to year. The Guidance provides a worksheet for the reporting of MOE expenses. The worksheet should be supported by documentation that can easily be examined by HRSA.
   Please refer to the ADAP Manual Section III.2.D and your HRSA Project Officer.

71. **Is there a standard fiscal assessment report (tool) for fiscal monitoring visits that HRSA requires the grantee to use?**
   No. There is no standard fiscal or program assessment tool or report however there are samples on the Target Center at the following link:
   http://www.careacttarget.org/category/topics/program-monitoring

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

Appendix 1

Source	**Available Online:**
Ryan White Treatment Extension Act of 2009	2009 legislation: http://www.gpo.gov/fdsys/pkg/PLAW-111publ87/html/PLAW-111publ87.htm

Code of Federal Regulations (CFR) and other federal, Department of Health and Human Services, and Public Health Service-specific grants management policies	Searchable listing: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl OMB Circulars in numerical sequence: http://www.whitehouse.gov/omb/circulars_default
HRSA/HAB Policies	Policies from 2001 forward, including policies updated in 2010 http://hab.hrsa.gov/manageyourgrant/policiesletters.html
Manuals and other policies, expectations, and guidance issued by HRSA/HAB	Part A Manual (online update, 2009) http://hab.hrsa.gov/Resources/partamanual/index.html Part B Manual (2003) http://hab.hrsa.gov/Resources/partbmanual/index.html ADAP Manual (updated November 2012) http://hab.hrsa.gov/Resources/adap/adapmanualfinalv9.0124d.pdf
Conditions of Award	Conditions of Grant Award accompany Notice of Award Assurances are an appendix to each year's Program Guidance Funding Opportunity
Office of Inspector General (OIG) report	OIG Report: The Ryan White CARE Act Title I and Title II Grantees' Monitoring of Subgrantees, March 2004: o http://oig.hhs.gov/oei/reports/oei-02-01-00641.pdf o https://oig.hhs.gov/oei/reports/oei-02-01-00641.pdf

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