CONSORTIA PROGRAM

ADMINISTRATIVE MANUAL

February 2001

Office of AIDS
Department of Health Services
State of California

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CONSORTIA PROGRAM ADMINISTRATIVE MANUAL

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CHAPTER ONE

INTRODUCTION

The Office of AIDS (OA) is pleased to provide you with a copy of the Consortia Program Administrative Manual. This tool was developed in response to requests for information focused specifically on the administrative requirements, both federal and state, that pertain to the Title II funded Consortia Program. In addition, this manual provides updated programmatic information regarding the Comprehensive AIDS Resources Emergency (CARE) Act Amendments of 2000, which emphasizes access to primary medical care for all populations.

We hope this manual will provide you with the technical assistance needed for administration of your Consortia Program. If you require further clarification or technical assistance, your Consortia Program staff are available to assist you.

USE OF THE CONSORTIA PROGRAM ADMINISTRATIVE MANUAL

The Consortia Program Administrative Manual has been prepared to assist fiscal agents and AIDS service providers in understanding the administrative requirements of the Consortia Program. In addition, the Administrative Manual provides example forms that may be used in the administration of the Consortia Program.

Certain Consortia Program requirements pertain only to specific eligible uses of the funds. Where requirements are specific only to certain activities, it is noted within the Administrative Manual.

Updates to the Administrative Manual will be provided periodically. The OA recommends that all parties responsible for the administration of Consortia Program funds become familiar with the information contained within this Administrative Manual. Additional copies may be obtained by contacting your consortia liaison.

CONSORTIA PROGRAM LEGISLATION

On August 18, 1990, Congress enacted Public Law 101-381, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. This legislation was reauthorized in May 20, 1996 and again on October 20, 2000. This Administrative Manual reflects the requirements as cited in the CARE Act and subsequent reauthorizations.

The CARE Act legislation is included as Exhibit 1. Copies of the Act and reauthorizations may be obtained via the internet at: http://thomas.loc.gov.

HRSA AND HAB POLICY MEMOS

The Health Resources and Services Administration (HRSA) through the HIV/AIDS Bureau (HAB) administer all Titles of the CARE Act. The OA receives Policy Memos from HRSA and HAB. Memos that directly affect the Consortia Program are forwarded to the appropriate Consortia Program staff via an OA Management Memo.

CONSORTIA PROGRAM MANAGEMENT MEMOS

Consortia Program Management Memos will be distributed by the OA periodically. They provide additional information and clarification regarding administration and use of the Consortia Program. Management Memos may also request information or acknowledgement of program compliance within a limited time frame. It is VERY important that fiscal agents and/or service providers are cognizant of these time frames and respond by the requested due date. It is recommended that Consortia Program Management Memos be retained with this manual and updated as necessary.

CHAPTER TWO

GENERAL PROGRAM OVERVIEW

Title II of the Ryan White CARE Act

On August 18, 1990, Congress enacted Public Law 101-381, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. This legislation was reauthorized in May 1996 and again in October 2000. All Titles of the CARE Act are administered by the Health Resources and Services Administration (HRSA) through the HIV/AIDS Bureau (HAB).

The Ryan White CARE Act is intended to help communities and states increase the availability of primary health care and support services, in order to reduce utilization of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life of those affected by the epidemic. The Act directs assistance through the following channels:

Title I — Awarded to Eligible Metropolitan Areas (EMAs) with the largest numbers of reported cases of AIDS, to meet emergency service needs of people living with HIV disease. EMAs are administered and funded directly by the HRSA through county health departments. Fifteen counties in California are included in the following nine EMAs:

- Inland Empire (Riverside & San Bernardino)
- Los Angeles
- Oakland (Alameda & Contra Costa)
- Orange
- Sacramento (Alpine, Placer, El Dorado, Sacramento)
- San Diego
- San Francisco (Marin, San Francisco, San Mateo)
- Santa Clara
- Sonoma

Title II — All states, the District of Columbia, Puerto Rico, and eligible U.S. territories receive funds to improve the quality, availability, and organization of health care and support services for individuals living with HIV disease and their families. The Department of Health Services Office of AIDS oversees the implementation and funding for the Title II Ryan White CARE Program in California.

Title III — Public and private nonprofit entities receive the funds to support outpatient early intervention HIV services for people living with HIV (PLWH). Title III is directly administered and funded by HRSA.

Title IV — Public and private nonprofit entities receive funds for projects to coordinate services and provide enhanced access to research for children,

youth, women, and families with HIV/AIDS. Title IV is directly administered and funded by HRSA.

Part F — Funds for Special Projects of National Significance (SPNS) to support the development of innovative models of HIV/AIDS care that are designed to be replicable and have a strong evaluation component; AIDS Education and Training Centers (AETC) to conduct education and training for health care providers; and the HIV/AIDS Dental Reimbursement Program to assist accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV-positive patients. Part F is directly administered and funded by HRSA.

CARE ACT FACT SHEET

Please see Exhibit 11 for a copy of the Title II Ryan White CARE Act fact sheet.

HRSA's GOAL AND FUNDAMENTAL PRINCIPLES

Goal

In a June 1999 letter (Exhibit 9), Dr. Claude Earl Fox, HRSA Administrator, communicated HRSA's goal regarding access to health care and eliminating disparities in health outcomes. Dr. Fox explained that HRSA's goal for all of its programs is to have "100% access to high quality health care and 0% disparity in health outcomes for recipients of HRSA-funded programs." He specifically emphasized that "the Ryan White CARE Act provides one of the only mechanisms whereby 100% access, 0% disparity can be achieved in the face of this epidemic."

Fundamental Principles

Better serving the underserved in response to the HIV/AIDS epidemic's growing impact among underserved minority and hard-to-reach populations. This requires states and territories and their planning bodies to assess the shifting demographics of new HIV/AIDS cases throughout the state or territory and adapt/change care systems to the needs of emerging communities and populations. States and territories should pay particular attention to reaching PLWH who are not in care and ensuring the provision of primary medical care and supportive services, directly or through appropriate linkages.

Ensuring access to existing and emerging HIV/AIDS treatments that can make a difference. The quality of HIV/AIDS medical care—including combination antiretroviral therapies and prophylaxis/treatment for opportunistic infections—can make a difference in the lives of PLWH. States and territories should focus on ensuring that available treatments are accessible and delivered according to established HIV-related treatment guidelines/recommendations.

Adapting to changes in the health care delivery system and the role of CARE Act services in filling gaps in care. States and territories need to consider how CARE Act services are utilized in filling gaps in care, including coverage of HIV/AIDS-related

services within managed care plans (particularly Medicaid) and coordination of CARE Act services with other funding sources.

Documenting outcomes. Policy and funding decisions at the federal level are increasingly being determined by outcomes. States and territories need to document the impact of CARE Act funds on improving access to quality care/treatment along with areas of continued need. States and territories also need to ensure that they have in place quality assurance and evaluation mechanisms to assess the effect of CARE Act resources.

These four factors have significant implications for the Nation's changing HIV/AIDS epidemic. HRSA's goal and these four factors must be the focus for ongoing and future OA and consortia activities.

INTENTION OF FUNDS

Subject to the availability of appropriations, HRSA makes grants to states to enable the states to improve the quality, availability, and organization of health care and support services for individuals and families with HIV disease.

Funds are intended to assist states and territories in developing, or enhancing access to a comprehensive continuum of high quality, community-based care for low income individuals and families with HIV disease. A comprehensive continuum of care includes:

- primary medical care (including treatment of HIV infection consistent with Public Health Service guidelines [i.e., treatment of HIV infection in the following areas; adults and adolescents, pediatrics, maternal health and for reducing perinatal HIV transmission, prophylaxis and treatment of opportunistic infections], access to drug therapies including opportunistic infections prophylaxis/treatment and combination antiretroviral therapies, substance abuse treatment, mental health, dental, and hospice services);
- supportive services that enable individuals to access and remain in primary care; and
- other health or supportive services that promote health and enhance quality of life.

The CARE Act emphasizes that such care and support be part of a continuum of care in which all the needs of individuals with HIV disease and their families are coordinated.

FEDERAL REQUIREMENTS OF THE CONSORTIA PROGRAM

Payor of Last Resort

The CARE Act stipulates that "funds received … will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by sources other than Ryan White funds. At the individual client level, this means that grantees and/or their subcontractors are expected to make reasonable efforts to secure other funding instead of CARE Act funds whenever possible. In support of this intent, it is an appropriate use of CARE Act funds to provide case management or other services which have as a central function ensuring that eligibility for other funding sources (e.g., Medi-Cal or Medicare, other local or State-funded

HIV/AIDS programs, or private sector funding, etc.) is agressively and consistently pursued.

Client Eligibility

Individuals and families with HIV disease are eligible for services. Proof of HIV diagnosis is required. The proof of HIV diagnosis must contain the client's name, i.e., physician diagnosis or positive test result with the client's name on the diagnosis or test result. Anonymous testing results are not acceptable.

Women, Infants, Children, and Youth (WICY)

A **minimum** percentage (set-aside) of each grant is designated to provide health and support services to **infected** women, infants, children, and youth. The CARE Act states, "For the purpose of providing health and support services to infants, children, and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, a State shall use, under this part for a fiscal year, **not less than the percentage** constituted by the ratio of the population of the State of infants, children, and women with acquired immune deficiency syndrome to the general population in the State of individuals with such syndrome."

Due to the rising incidence of HIV among youth, the Ryan White CARE Act Amendments of 2000 added youth as a new category within the WIC set-aside. The term youth includes persons between the ages of 13 and 24, see the chart below for other definitions. A list of WICY allocations is attached to each contract. Fiscal agents may choose to allocate a portion of the minimum percentage for their county to each of their service providers. The goal of the minimum allocation is to spend **at least** that amount on the infected WICY population. Fiscal agents must ensure that a system is in place to accurately capture actual WICY expenditures. WICY expenditures reported in the mid-year and year-end reports must reflect actual expenditures. WICY is a target population and funds spent over the minimum allocation are a positive indication that services are being delivered to this population.

Category	Age
Infants	0 – 1 yr
Children	2 – 12 yrs
Youth	13 – 24 yrs
Women	Females over the age of 25 yrs

Income Guidelines

Most providers do not charge for services. Providers who charge for services must comply with the following requirements regarding imposition of charges for services:

A. In the case of individuals with an income less than or equal to 100 percent of the official poverty line, the provider will not impose charges on any such individual for the provision of services under the Consortia Program grant;
B. In the case of individuals with an income greater than 100 percent of the official poverty line, the provider:
   1. Will impose charges on each such individual for the provision of such services; and
   2. Will impose charges according to a schedule of charges that is made available to the public.
C. In the case of individuals with an income greater than 100 percent of the official poverty line and not exceeding 200 percent of such poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 5 percent of the annual gross income of the individual involved;
D. In the case of individuals with an income greater than 200 percent of the official poverty line and not exceeding 300 percent of such poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 7 percent of the annual gross income of the individual involved; and
E. In the case of individuals with an income greater than 300 percent of the official poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 10 percent of the annual gross income of the individual involved.

Service Categories

Social and support services funded by the CARE Act, along with a detailed description of each service, are listed in Exhibit 4. Only those services described in Exhibit 4 can be funded through the Ryan White CARE Act.

Additional Guidance on Allowable Uses of Funds for Service Categories

The following policy memos (copies are included as Exhibit 5) have been issued by HRSA:

- Program Policy Notice (PPN) No. 97-01 and 97-02, first issued February 1,1997, and revised June 1, 2000
- PPN 97-03 first issued March 31, 1997 and revised June 1, 2000

The following provides clarification regarding HRSA's guidance:

- Funds may **not** be used:
  - To purchase or improve (other than minor remodeling) any building or other facility
  - For items or services that have already been paid for, or can reasonably be expected to be paid for by another source
  - To pay for automobile parts, repairs, or maintenance
  - To make cash payments to people receiving services under this Act

- To pay for pet care or supplies
- To purchase tobacco, lotto tickets, or any other non-food items
- To purchase personal care products such as, but not limited to, cleaning supplies and personal care items
- To purchase medical marijuana
- For complementary therapy – this category, which was under Other Services, was removed by HRSA. The Consortia program may no longer pay for complementary therapies such as massage, Chinese herbal therapy, etc.

- Bulk Purchases: The State Office of AIDS Management Memo 00-03 (included in the Mangement Memo Section) outlines the policy regarding bulk purchase(s) of products or vouchers.

- Housing Referrals: The State Office of AIDS Management Memo 99-08 (included in the Management Memo Section) summarizes and transmits the HIV/AIDS Bureau (HAB) Policy Notice 99-02. The HAB policy notice describes the conditions under which housing and related services may be funded.

- Diagnostics and Laboratory Tests: The State Office of AIDS Management Memo 00-01 (inlcuded in the Management Memo Section) summarizes and transmits the HAB Policy Notice 99-03. The HAB policy notice describes the use of the Ryan White CARE Act funds for HIV diagnostics and laboratory tests. Diagnostics and laboratory tests are included under the service category Ambulatory/Outpatient Medical Care.

- Direct Emergency Financial Assistance: In order to utilize this category, guidelines for expenditures must be established by the fiscal agent and consortia (if applicable), and carefully monitored to ensure limited amounts, limited use, and for limited periods of time. Expenditures must be reported under the relevant service category.

- Partner Counseling and Referral System (PCRS): Federal law requires that any health department receiving Ryan White CARE Act Title II funds take action to ensure that a good faith attempt is made to inform spouses of HIV positive persons of their risk. According to this legislation, “marital spouses” are defined as any past or present legally married partner within ten years of the diagnosis of HIV infection.

CHAPTER THREE

PROGRAM ADMINISTRATION

ADMINISTRATION OF THE CONSORTIA PROGRAM IN CALIFORNIA

The State of California, Department of Health Services, Office of AIDS (OA) implements and oversees the Consortia Program in California under the guidance of HRSA.

CONSORTIA PROGRAM STAFFING

The OA contracts with county health departments and community-based organizations (CBOs) to implement the Consortia Program in California. The fiscal staff contact member at the County Health Department or CBO is called the fiscal agent. Each Consortia Program is assigned an OA staff contact person. The OA staff person assigned is called a consortia liaison. The consortia liaison provides technical assistance and contract oversight. Please see Exhibit 2 for a complete listing of fiscal agents and Exhibit 3 for a listing of consortia liaisons.

SERVICE MODELS

Two service delivery models utilized in California are the Consortia Program and Direct Services Program. Though these two models are separate funding categories eligible under the Act, the OA refers to both as the Consortia Program.

Consortia Program

In this model, the consortium conducts or updates an assessment of HIV/AIDs service needs for their geographical area, establishes a service delivery plan based upon prioritized services, coordinates and integrates the delivery of HIV-related services, assures the provision of comprehensive outpatient health and support services, evaluates the consortium's success in responding to service needs, and evaluates the cost-effectiveness of the mechanisms used to deliver comprehensive care.

Direct Services Program

On April 1, 2000, the State implemented a pilot approach to delivery of Title II services in areas where consortia were no longer present. OA's primary goal is to provide a funding and service delivery mechanism that will ensure the ongoing and uninterrupted provision of services to persons living with HIV/AIDS. In this model, the fiscal agent convenes an advisory group, which includes infected and affected community members, who will meet no less than once per program year. The advisory group provides input into the needs assessment and comprehensive planning processes.

In both models of service delivery, the flow of funding is the same. Please see Chapter 5 for consortia roles and responsibilities and Chapter 4 for fiscal agent roles and responsibilities.

FLOW OF FUNDING FOR THE CONSORTIA PROGRAM IN CALIFORNIA

Federal Grant (from HRSA) to State

—

State of California Department of Health Services
Office of AIDS

—

Fiscal Agent

—

Service Providers

—

Services to people living with HIV disease

APPLICATION PROCESS

Federal Application Process:

Annually, OA prepares and submits a grant application to HRSA. The grant application is similar to the application submitted by fiscal agents to OA i.e., it includes budget detail, goals and objectives narrative and addresses specific questions posed by HRSA. OA depends on the information provided by fiscal agents and service providers in the mid-year and year-end reports, management memo responses, and invoices to develop the application package. It is imperative that the information submitted to OA is timely and accurate.

State Application Process:

The OA annually prepares and transmits an application package to all fiscal agents and consortia chairpersons. The package includes: guidelines on how to complete the application, forms to be utilized, a list of services that may be funded, goals for the upcoming year, and for technical assistance, a list of consortia liaisons and their assigned areas.

It is vital that the application be completed and returned to the OA by the due date. Timely submission ensures time for each consortia liaison to review and approve the applications and submit them to the OA Contracts Unit to ensure that contracts are prepared and executed before the new contract year begins April 1.

TIERED APPROACH

HIV service needs and resources vary significantly in a state as geographically, culturally and economically diverse as California. Service needs of existing and emerging populations, cultural issues, administrative capacity, technical assistance needs, and available funding differs greatly throughout the state; it's imperative that the Consortia Program address these changing needs by maintaining the flexibility needed to address service needs in these varying local environments.

The OA developed a tiered approach to begin addressing two areas of concern identified by various fiscal agents and consortia—increased administrative responsibilities and imbalanced funding levels. These issues have been addressed through the development of three categories, or tiers, of counties where funding levels, as well as administrative responsibilities, will be established at a level commensurate with local needs and utilization.

Tier A: <u>Counties</u> Alpine Colusa Del Norte Glenn Inyo Modoc Mono Plumas Sierra	• Tier A counties are identified as counties with six or fewer Persons Living With AIDS (PLWA) or persons served*. • Tier A counties may utilize the Direct Services approach to the delivery of HIV services. • Non- Eligible Metropolitan Area (EMA) multi-county regions that include Tier A counties are provided the option to utilize the Direct Services or Consortia model. • Tier A counties will receive a Year 11 allocation based upon the higher of the following: ➢ Statewide HIV funding average per capita ($4,175) ➢ Formula allocation (not subject to 95 percent hold harmless) ➢ Established Year 11 floor of $30,000 • Tier A counties will receive a Year 12 allocation based upon the higher of the following: ➢ Statewide HIV funding average per capita (to be determined) ➢ Formula allocation (not subject to 95 percent hold harmless) ➢ Established Year 12 floor of $15,000 *Of particular importance to creation of this model was the need to determine the number of persons accessing services in each county. AIDS Drug Assistance Program (ADAP) and Medi-Cal data, which provided the number of persons per county accessing those two programs for HIV medications, were considered to be the most reliable indicators currently available for determining the number of eligible persons accessing HIV services in each county.

Tier B: Counties Fresno Kern Monterey Santa Cruz Solano Stanislaus	• Tier B counties are those counties significantly impacted by increased demand for services, as demonstrated through caseload data, increasing persons accessing services, increasing PLWA, decreasing Title II Consortia Program funding, and per capita HIV/AIDS funding that falls below the statewide average. • Tier B counties receive an allocation based upon the formula. In addition, Tier B counties will receive a pro rata augmentation of Consortia Program funds in Program Years 11 and 12.
Tier C:	• Tier C counties are those EMA and non-EMA counties that do not fall into Tiers A or B, and will not be subject to funding or significant administrative revisions in Year 11. • Tier C counties will receive an allocation based upon the formula.

Resource Allocation

Funding for the Consortia Program was allocated to counties on a formula basis, which is based primarily upon the total persons living with AIDS in each county. The allocations were subject to a 95 percent hold harmless provision that was developed to protect counties from receiving large funding decreases resulting solely through utilization of the formula.

The statewide California HIV Planning Group (CHPG) makes recommendations to the OA regarding the process for allocating Consortia Program funds. The CHPG determined that certain counties have experienced dramatic increases in the number of clients served, while disproportionately larger allocations have been made to counties with relatively few clients. The allocation process has created funding imbalances and has not kept pace with the needs of counties experiencing dramatic increases in service needs. The CHPG recommended that, due to these imbalances and HRSA's emphasis on access to HIV services, the allocation process be revised.

Revised Approach to Resource Allocation

The OA accepted CHPG's recommendation to develop a tiered approach to the allocation of Consortia Program resources. This revision will be phased in throughout program years 11 and 12. Of particular importance to creating this model was the need to determine the number of persons accessing services in each county. ADAP and Medi-Cal data, which provided the number of persons per county accessing those two programs for HIV medications, were considered to be the most reliable indicators currently available for determining the number of eligible persons accessing HIV services in each county. Please see Chapter VII for a copy of Management Memo 01-01 that details the Tiered Approach.

STANDARD AGREEMENT

A standard agreement (Exhibit 13) is a contract.

Amendments

Should either party during the life of the contract desire to change the contract, such changes shall be proposed in writing to the other party who will within 30 calendar days of the receipt of the request, accept, or reject the proposed changes in writing. Once accepted, the contract shall be amended to provide the change mutually agreed upon.

In-House Revisions

An In-House Revision is an internal OA form used to make line-item revisions. Please see Exhibit 13, Allowable Line Item Shifts for specific line-item shift guidelines.

Encumbrances

The State fiscal year is July 1 through June 30. The Consortia Program year, April 1 through March 31, overlaps the State fiscal year. Funds are encumbered for forty percent of the maximum allowable amount under the contract for the Consortia Program through June 30. Sixty percent of the maximum amount allowed under the contract is encumbered for July1 through March 31. Any funds not expended during April 1 – June 30 are disencumbered and moved to help cover expenditures for the remaining Consortia Program year. When expenses are incurred April 1 – June 30 and are not invoiced in those months, a supplemental invoice may be submitted. The consortia liaison must be notified by January 1 if a supplemental invoice will be submitted.

INVOICING PROCESS

The fiscal agent is responsible for implementing and monitoring a system to administer Title II funds using standard accounting practices. The Consortia Program is a reimbursement program; services are provided before an invoice is submitted to the fiscal agent.

The following table describes the invoice process.

Service Providers	Fiscal Agent
• Provide service, send invoice to fiscal agent. (Due date is determined by the fiscal agent.) • Provide back-up documentation with the invoice unless the fiscal agent conducts quarterly monitoring visits. • Keep invoice documentation for a minimum of 3 years following the date of final payment authorization. • If documentation identifies client, it must be kept in a locked, secure area to ensure client confidentiality.	• Pay service providers, submit monthly or quarterly invoice to OA. • Invoices are due 45 days following the end of a billing period. For example: ➢ Monthly invoices: An invoice for April services is due June 15. ➢ Quarterly invoices: An invoice for services provided in the first quarter is due August 15. • Invoices must be on the agency's letterhead in the approved format (see Exhibit 6).

Service Providers	Fiscal Agent
• Final invoice due date is determined by the fiscal agent.	• Invoices must include an invoice detail form (see Exhibit 7). • Final invoices are due 90 days following the expiration date of the contract.

Prompt Payment Act

As of January 1, 1999, all state agencies are required to comply with the provisions of the California Prompt Payment Act. This act requires that state agencies pay undisputed invoices within 45 calendar days (30 days for small businesses – County Health Departments are exempt). It also requires state agencies to automatically calculate and pay late payment penalties if undisputed invoices are not processed and paid by the date required. Late payment penalties will be paid from the state agency's support funds.

To comply with the requirements of this act, the OA fiscal analyst must approve or deny invoices within three working days. Due to this timeframe, the OA fiscal analyst may not have the opportunity to contact agencies to correct invoice errors. Any incorrect invoices will be returned to the fiscal agent and payment will be delayed until a correct invoice is received and processed.

Some common invoice errors are:

- No signature
- Mathematical errors
- Advances not included
- Line items overspent

Monthly vs. Quarterly Invoicing

Fiscal agents have the option to invoice quarterly or monthly. This decision is made at the beginning of the contract year and communicated to the consortia liaison.

Advances and Repayment of Advances

Private nonprofit agencies may request advance payments up to 25 percent of their total Consortia Program budget. Agencies receiving $200,000 or less may request one or two advances; agencies receiving over $200,000 may request only one advance. The Consortia Program contract year (April 1 – March 31) crosses over the State fiscal year (July 1 – June 30). The table on the next page explains the advance process.

If you request	Then
One Advance	Processing will be delayed until passage of the annual State Budget Act.
Two Advances	You will receive: • One advance for up to 8 percent, and • One advance for up to 17 percent **Caution**: The second advance will not be processed until passage of the annual State Budget Act.

The fiscal agent may ask for an advance by submitting a written request on agency letterhead to the consortia liaison. The request should include:

- Contract number
- County name(s)
- Number of advances:
  - ➢ One advance for a maximum of 25 percent, liquidated beginning the month after the State Budget Act passes and completed by March 31.
  - ➢ Two advances – one for up to 8 percent, liquidated with the May and June invoices; and one for up to 17 percent, liquidated with the September through March invoices
- Bank account number*
- Name and address of bank

*All advances must be placed in a interest-bearing account.

MID-YEAR FUND REALLOCATION PROCESS

To ensure that all CARE Act funds are expended by March 31, current and prior year financial status reports are reviewed by the consortia liaisons to identify those agencies with demonstrated low expenditure rates. These agencies are contacted and asked to respond to questions such as:

- Will you expend 100 percent of your funds by March 31?
- If you plan to expend 100 percent of your funds, what is your plan for ensuring 100 percent expenditure?
- If you do not plan to expend 100 percent of your funds, what percentage do you plan to relinquish?
- If you are relinquishing funds, what percent of the funds are designated for Women, Infants, Children, and Youth?

The relinquished funds are allocated to Consortia Programs who can expend the funds for Primary Medical Care by March 31. Relinquishing funds **does not** affect future allocation amounts.

MONITORING

By OA

In accordance with Ryan White CARE Act requirements, OA consortia liaisons monitor Ryan White CARE Act contracts. The goal of contract monitoring is to ensure compliance with State and Federal contract requirements. OA's focus is to help fiscal agents and service providers to avoid noncompliance and to provide technical assistance as appropriate to ensure continued compliance. Contract monitoring is undertaken as needed or every three years and includes both program and fiscal monitoring activities.

Program monitoring means assessing the quality and quantity of the services being provided by a particular contractor. Program monitoring may include reviewing program reports, conducting site visits, and reviewing client records or charts.

Fiscal monitoring means assessing how quickly and efficiently a contractor uses the CARE Act funding it receives and whether funds are used for approved purposes. Fiscal monitoring includes regular review and assessment of contractors' expenditure patterns and processes to ensure adherence to Federal, State, and local rules and guidelines on the use of CARE Act funds.

By the Fiscal Agent

Annual onsite monitoring of all service providers, by the fiscal agent, is required. Annual onsite monitoring provides each fiscal agent the opportunity to ensure contractual compliance, effective and efficient use of program funds, and adherence to corrective action plans. OA monitors fiscal agents and utilizes monitoring tools during monitoring visits to fiscal agents and their service providers. The tools are revised annually to reflect current fiscal agent contractual requirements. Fiscal agents may choose to use the service provider monitoring tool during their annual visits. If you would like a copy of this tool, please contact your consortia liaison.

REPORTING REQUIREMENTS

OA as grantee for Consortia Program funding, must comply with HRSA reporting requirements. Fiscal agents are therefore required to submit reports, in a timely manner, to the Office of AIDS. Failure to submit these reports by the due date may result in a 10 percent reduction of administrative monies. The reports fiscal agents are required to complete are:

Report	Due Date(s)
Mid-Year and Year-End Reports	Mid-Year – 11/15 Year-End – 6/15
Annual Administrative Report (AAR)	12-month report (Jan. – Dec) – 2/15

Mid-Year and Year-End Reports

The two components of the mid-year and year-end reports are:

1. Financial Status Report

   The fiscal agent lists on the form (Exhibit 8*):

- each service provider
- total dollars allocated to each service provider
- dollars expended to date
- remaining balance
- percentage expended
- number of unduplicated clients served
- total dollars allocated to each service provider for HIV/AIDS infected women, infants, children and youth
- amount expended to date
- remaining balance

   *If you would like a copy of the form formatted in excel, contact Estella Kile, Fiscal Analyst at (916) 327-6771.

2. Narrative Report

   The Narrative Report provides an opportunity for the fiscal agent to describe the progress made in achieving the administrative and service delivery goals and objectives outlined in the application and identify any technical assistance needs.

Annual Administrative Report (AAR)

The AAR consists of client and service data collected by the fiscal agent throughout the year.

Due Date	Data Collection Period
February 15	January 1st through December 31st

The Ryan White Contract period is April 1 through March 31. The AAR report, due February 15, is a twelve-month report which consists of data collected from the previous contract year January through March and the current contract year April 1 through December 30. Please see Exhibit 10 for a sample of the AAR forms and instructions for completion. If you would like a copy of the Annual Administrative Report (AAR) Guidance Manual please contact Denise Absher, OA, at (916) 322-3150.

Data Elements

The data elements included in the AAR are listed below. Fiscal agents, through the contract with the OA agree to comply with future data requirements developed by the Federal program staff and the State.

Annual Administrative Report (AAR)
Data Elements

I. Provider Agency Contact Information
   1. Provider Name
   2. Provider Address
   3. Provider AAR Contact Name, Title, Phone Number, Fax Number, and E-Mail Address
   4. Reporting Period
   5. Type of Agency Completing the Report
   6. Reporting Scope

II. Program Information
   1. Grantee ID # (0600 – All California Title II providers have the same grantee number)
   2. Provider Number
   3. Provider Taxpayer ID #
   4. Zip Code of Principal Provider Site
   5. Total Number of Provider Sites
   6. Provider Type
   7. Ownership Status
   8. Racial/Ethnic Constitution of Board and Racial/Ethnic Constitution of Professional Staff
   9. Total Paid Full Time Equivalents (FTEs)
   10. Total Volunteer Staff FTEs

III. Client Information/Demographics
   1. Total Number of Unduplicated Clients During the Reporting Period
   2. Total Number of New Clients Served in During the Reporting Period
   3. Gender Distribution of Clients
   4. Racial/Ethnic Distribution of Clients
   5. Age Distribution of Clients
   6. HIV/AIDS Status (Percent of HIV+ Clients not Diagnosed with AIDS; Percent of HIV+ Clients Diagnosed with AIDS)
   7. Primary Exposure Category

IV. Services Provided/Clients Served
   1. Medical Services: Total number of clients receiving services AND total number of office visits for the services received for the following services:
      a.) Medical Care
      b.) Dental Care
      c.) Mental Health Treatment/Therapy or Counseling

d.) Substance Abuse Treatment/Counseling
e.) Face-to-Face Case Management
f.) Other Case Management (not face-to-face)
g.) Rehabilitation
h.) Home Health Paraprofessional Care
i.) Home Health Professional Care
j.) Home Health Specialized Care

2. Support Services: Total number of clients receiving the following services:
   a.) Residential or In-Home Hospice Care
   b.) Buddy/Companion Service
   c.) Client Advocacy
   d.) Day/Respite Care
   e.) Emergency Financial Assistance
   f.) Housing Assistance
   g.) Food Bank/Home Delivered Meals
   h.) Transportation Services
   i.) Service Outreach/Secondary Prevention Counseling
   j.) Other Counseling (not mental health)
   k.) Permanency Planning
   l.) Other Services

V. Fiscal Information
1. Annual HIV/AIDS Funding (for HIV/AIDS program):
   a.) Title I CARE Act Funding
   b.) Title II CARE Act Funding
   c.) Other CARE Act Funding
   d.) Expenditures for Medications Not Reported on a State or Local AIDS Pharmaceutical Assistance Annual Administrative Report

VI. Fee-for-Service Providers (if applicable)
1. Number of Fee-for-Service Providers for Whom You are Submitting Data
2. Type of Provider
3. Ownership Status
4. Racial/Ethnic Constitution of Board and Racial/Ethnic Constitution of Professional Staff for Fee-for-Service providers

Data Collection Options

- Ryan White CAREWare: This software is supported and supplied free of charge by HRSA. For more information, please contact John Milberg at (301) 443-8729.
- Continue with your current data collection system provided that the system is Y2K compliant and meets HRSA's specifications for submitting files electronically. TOOLBOX software, which many fiscal agents utilized, is not Y2K compliant.
- Office of AIDS data collection software program. This program consolidates data from both the Case Management Program (CMP) and the Ryan White Title II Consortia Program. For more information, please contact Denise Absher at (916) 322-3150.

- Scannable Form: You may submit data utilizing a scannable form provided by HRSA. Data must be submitted on the original HRSA form, it may not be copied. The scannable forms are available in January. For more information, please contact Denise Absher at (916) 322-3150.

Client Level Data Reporting

Currently the Title II Consortia Program collects data twice a year. Each data submission requires provider agencies to submit aggregate level data. This type of data collection does not allow the Title II Consortia Program to follow clients and services across providers, counties, or consortia. Therefore, the Consortia Program is exploring ways to collect client-level data to ensure accuracy and usefulness of Title II Consortia Program data.

The OA would like to phase in client-level data reporting based on the readiness of the provider agency and county. Those who are software ready, i.e., those providers who are currently using software allowing them to collect and input client-level data, may be brought into the first phase of the project. All other agencies will be brought into the second phase of the project as they become software ready. Examples of client-level data software include the Ryan White CAREWare (distributed by the Health Resources and Services Administration [HRSA]) and the CMP/Consortia database (distributed by the OA). This software is available free of charge from their respective agencies.

Please note that client-level data will not necessarily result in the collection of additional data elements; in most cases, client-level data reporting will influence the process with which you report data, not collect data. While you may report data more frequently, the processes by which you collect data more than likely will not change.

While details of the first and second phase and reporting periods and dates are not yet available, the OA will likely follow-up with a schedule of events leading to client-level data collection. The OA will provide agencies with ample notice and direction before the client-level data collection process begins.

AUDIT REQUIREMENTS

A-133 Audit Requirements

The Federal Office of Management and Budget's (OMB) Circular No. A-133 – Revised June 24, 1997, Audits of States, Local Governments, and Non-Profit Organizations, sets forth standards for obtaining consistency and uniformity among federal agencies for the audit of states, local governments, and non-profit organizations expending federal awards. OMB Circular No. A-133 states that a non-federal entities (state, local government, or non-profit organization) that expend $300,000 or more in a year in federal awards shall have a single or program-specific audit conducted for that year. Exhibit A(F) in the contract between the fiscal agent and OA, requires that the audit be completed by the 15th day of the fifth month following the end of the contractor's fiscal year. Exhibit A(F) also requires that within 30 days after the completion of the audit, two copies of the audit report be sent to OA. A copy of OMB Circular No. A-133 may be

obtained by contacting the Office of Administration, Publications Office, Room 2200, New Executive Office Building, Washington, DC 20503 at (202) 395-7332.

DHS Audits

OA utilizes the Department of Health Services, Financial Audits Section, to conduct an audit of any entities receiving Title II CARE Act Program funds. Higher priority for audit is given to agencies receiving significant monitoring findings or upon closeout of a contract with the OA.

ADMINISTRATIVE FUNDS

Administrative Funding Restrictions

Fiscal agents may receive up to ten (10) percent of the total grant amount for administration of the Title II CARE Act Program. This allocation includes the administration and monitoring for:

- Development of applications for funds
- Receipt and disbursal of program funds
- Development and establishment of reimbursement and accounting systems
- Preparation of routine programmatic and financial reports
- Compliance with grant conditions and audit requirements

Upon written request to the OA, fiscal agents may receive up to five (5) percent of the total grant amount for the development, implementation, and evaluation of a needs assessment.

Indirect and Operating Expenses

Fiscal agents may use up to 10 percent of the total grant amount for administration of the Consortia Program. This allocation includes indirect and operating expenditures.

Indirect expenses are typically those expenses that cannot be assigned to one program. Often this category is used when a service provider administers multiple programs and funding sources and divides the rent, utilities, office supplies, janitorial services, etc., either equally between programs or based on the percentage of time spent on a program. Indirect expenses are limited to 15 percent of the total personnel costs.

Operating expenses are typically those expenses that can be assigned to a specific program such as office supplies, postage, facilities operations, and telephone costs.

PROGRAM EVALUATION

Information to follow.

STANDARDS OF CARE

Information to follow.

QUALITY ASSURANCE/QUALITY IMPROVEMENT

Information to follow.

CHAPTER FOUR

FISCAL AGENT: ROLES AND RESPONSIBILITIES

The fiscal agent's role is imperative to the success of the Title II CARE Act Program in California. The fiscal agent, via contract with the State of California Office of AIDS (OA), performs multiple financial and oversight tasks to ensure the efficiency and effectiveness of program expenditures.

OVERVIEW OF FISCAL AGENT RESPONSIBILITIES

- Administer Title II funds, maintain records, and invoice using standard accounting practices, coordinate federal and state data reporting, arrange for fiscal audits
- Establish and implement a procurement mechanism to select service providers
- Establish subcontracts with service providers
- Implement subcontract invoice and monitoring systems
- Respond to all management memorandums and provide reports in a timely manner
- Evaluate subcontractors to ensure that:
  - Medical care meets, at a minimum, Public Health Service guidelines
  - Medical subcontractors have continuous quality improvement systems
  - Clients use any and all available third party payer funds prior to using CARE Act funds. This includes local private non-profit funding typically available, as well as federal, state, or county programs and private insurance.
- Complete all required fiscal documentation for the annual application
- Ensure that the consortium (if applicable) meets is responsibilities under the grant
- Ensure that CARE Act funds do not exceed 60 percent of subcontractor's budget

REQUIREMENTS TO PERFORM THE ROLE OF FISCAL AGENT

To be a fiscal agent you must be a local government agency, i.e., health department, or a private nonprofit organization. Private nonprofit organizations must have:

- Demonstrated experience with generally accepted accounting principals.
- Sufficient cash flow to assure no disruption in services in the event of invoicing reimbursement delays.
- Legal entity status.
- Program management experience.

FISCAL AGENT'S ROLE IN THE STATE APPLICATION PROCESS

The OA annually prepares and transmits an application package to all fiscal agents and consortia chairpersons. The package includes: guidelines on how to complete the application, forms to be utilized, a list of services that may be funded, goals for the upcoming year, and for technical assistance, a list of consortia liaisons and their assigned areas.

It is the fiscal agent's responsibility to ensure the application is completed accurately and submitted to OA by the due date. Timely submission ensures time for each consortia liaison to review and approve the applications and submit them to the OA Contracts Unit to ensure that contracts are prepared and executed before the new contract year begins April 1.

REQUEST FOR APPLICATION (RFA) PROCESS

Once the service categories and percentages (or if known, the dollar amounts) allocated to those services are determined, the fiscal agent secures contractors to provide the services. The fiscal agent, whether a county agency, local health jurisdiction, or community-based organization, has sole responsibility for all phases of the contracting process including:

- Advertising
- Receiving bids
- Creating a bid evaluation process
- Awarding bids
- Creating an appeal process
- Resolving appeals, and
- Any other activity involved with the contracting process

Appeal Process

Some RFA appeal processes indicate that appeals will be voted on by the consortium, or have some other type of response on the part of the consortium or the OA. **Consortia and/or the OA are <u>not</u> involved in the RFP, contracting, or appeal process**. The appeal process used by the fiscal agent should be the same as for any other contract managed by the fiscal agent. For example, contracts awarded by a county would be appealed through the county's established process. This process may involve many review levels, and may result in a final decision by the county board of supervisors. Likewise, contracts awarded by a community-based organization usually have an executive board who hears and makes decisions regarding contract appeals.

Awards to Service Providers

Private for-profit service providers may be used only when there are no nonprofit organizations able and willing to provide quality HIV services and the fiscal agent is able to document this fact. The definition of quality HIV care includes: …entity should only be deemed incapable of providing quality HIV care if written documentation of substantive quality of care deficiencies exists. Cost of service may not be the sole determinant in the vendor selection processes whether internal or external. Grantees must prohibit nonprofit contractors from serving as conduits who pass on their awards to for-profit corporations and may find it necessary to monitor membership of corporate boards in enforcing this prohibition. Proof of nonprofit status should be required of all applicants claiming such status. Any nonprofit provider able to provide quality HIV care is given legislative preference over for-profit entities seeking to serve the same area.

Sixty Percent Restriction Limit

The fiscal agent must ensure that Consortia Program monies do not comprise more than 60 percent of any subcontractor's total budget. Ryan White monies are not to be the sole source funding for any agency.

Subcontracts with Service Providers

The fiscal agent is responsible for ensuring that all Consortia Program contracts incorporate the requirements of the prime contract (Exhibit 14) which are relevant to the services provided by the subcontractor.

RESPONSE TO MANAGEMENT MEMOS

Management Memorandums (MMs) are sent periodically throughout the year. MMs provide additional information and clarification regarding administration and use of the Title II Program funds. MMs may also request information or acknowledgement of program compliance within a limited time frame. Most often, MMs transmit information or request information that HRSA has requested from the OA. In order for the OA to be in compliance with HRSA, this information must be submitted in a timely manner. It is VERY important that fiscal agents and/or service providers are cognizant of these time frames and respond by the requested due date. Failure to submit a response to MMs by the required date may result in a reduction in administrative monies.

OVERSEEING AND SUPPORTING THE HIV CARE CONSORTIA

Participation at Meetings

The fiscal agent is responsible, via contractual agreement with the OA, for financial expenditures and oversight of the administration of the Consortia Program in their designated area. The fiscal agent or a representative must be present at all consortia meetings. OA requires the fiscal agent be a member of the executive and finance committee if they are established.

The Brown Act

The Fiscal Agent and the Consortium are required to follow the Ralph M. Brown Act during consortium meetings. The Ralph M. Brown Act governs open meetings for local government bodies. Included in the Ralph M. Brown Act are definitions of a quorum, meetings, notice and agenda requirements, rights of the public, permissible closed sessions, and penalties and remedies for violation of the Act. To obtain a copy of the Ralph M. Brown Act contact:

Attorney General's Office
Public Inquiry Unit
P.O. Box 944255
Sacramento, CA 94244-2550
1 (800) 952-5225

Agenda and Minutes

Each consortium's policies and procedures should outline who is responsible for preparing the agenda and minutes. Typically, the fiscal agent is responsible for mailing the agenda and minutes because the cost of mailing is covered in the fiscal agent's administrative budget.

Advisory Groups

The Direct Services category of the CARE Act allows states to directly fund services in the absence of a consortium or when this approach is proven to be more beneficial to the delivery of services. OA directly contracts with local fiscal agents that provide or subcontract HIV services. Fiscal agents are solely responsible for the completion of planning documents and other documents typically required of consortia. OA acknowledges the importance of public input in the development of local care plans and mandates that each fiscal agent periodically convene an advisory group to assist in the development of planning documents, as needed. The Brown Act does not govern advisory groups.

CHAPTER FIVE

SERVICE PROVIDER: ROLES AND RESPONSIBILITIES

OVERVIEW OF SERVICE PROVIDER RESPONSIBILITIES

- Deliver quality services, designated by the fiscal agent, to HIV/AIDS eligible clients
- Ensure client eligibility
- Comply with all components of the contract with the fiscal agent and applicable components of the contract between the fiscal agent and the OA
- Implement and maintain an invoice system using standard accounting practices
- Establish, implement and evaluate a continuous quality improvement system
- Provide reports that are accurate and complete to the fiscal agent by requested due date
- Ensure that all clients who receive services use any and all available third party payer funds prior to using CARE Act funds
- Maintain appropriate client forms, including intake, budget worksheet, service plan, client rights and responsibilities and verification of client eligibility
- Ensure that CARE Act funds do not exceed 60 percent of the agency's budget or any subcontractor's budget
- Collect and maintain back-up documentation for all invoices submitted to the fiscal agent for payment (invoices are to be based on cost as stated in the service provider's application budgets)
- Submit characteristics data to the fiscal agent as part of the annual application for Ryan White Title II funds and whenever changes occur
- Secure fiscal agent's approval prior to release of any publicity regarding the CARE Act
- Ensure confidentiality of all client records

APPLYING FOR FUNDS

The OA annually prepares and transmits an application package to all fiscal agents and consortia chairpersons. The package includes: guidelines on how to complete the application, forms to be utilized, a list of services that may be funded, goals for the upcoming year, and for technical assistance, a list of consortia liaisons and their assigned areas.

Service providers must accurately complete their budget sheets and submit them to the fiscal agent by the designated due date. If service providers have any questions on how to complete their budget sheets, they should contact their fiscal agent.

It is vital that the application be completed and returned to the OA by the due date. Timely submission ensures time for each consortia liaison to review and approve the applications and the OA Contracts Unit to prepare and execute the new contract before the new year begins April 1.

SIXTY PERCENT RESTRICTION LIMIT

Ryan White monies must not comprise more than 60 percent of any service provider's total budget. Ryan White monies cannot be the sole source funding for any agency.

COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS

The contract between the fiscal agent and service provider must incorporate the requirements of the prime contract (Exhibit 14) which are relevant to the services provided by the service provider.

PARTICIPATION AT CONSORTIA MEETINGS

Service providers are encouraged to participate as voting members of the Consortium and participate in Consortia subcommittees. However, they may not vote on issues that could be considered to be a conflict of interest. HRSA defines conflict of interest as "an actual or perceived interest by a member in an action which results in, or has the appearance of resulting in, personal, organizational, or professional gain."

ADMINISTRATIVE EXPENSES

Individual accounting systems determine whether or not indirect expenses, operating expenses, or both are utilized. Administrative expenses include:

- **Indirect Expenses** – typically those expenses that cannot be assigned to one program. Often this category is used when a service provider has multiple programs and divides the rent, utilities, office supplies, janitorial services, transportation, etc., either equally between programs or based on the percentage of time spent on a program. **Indirect expenses are limited to 15 percent of the total personnel costs.**
- **Operating Expenses** – typically those expenses that can be assigned to a specific program but are not dedicated to providing the service. For example, a case manager who travels to see clients. The travel expense is part of that service, not an operating expense. Budgeting travel for state-required training would be an operating expense. Operating expenses might include office supplies, postage, facilities operations, telephone, etc.
- **Equipment** – the CARE Act limits equipment purchases. Contact the fiscal agent for information regarding a specific equipment request.
- **Administrative Support** – are services provided that are not direct services to clients. For example, administrative costs would include:
  - The Executive Director if that person does not provide direct service to clients
  - Accounting staff
  - Receptionist staff if that person does not provide direct service to clients. If the receptionist makes appointments for all people who come to the agency, including vendors, this is not a direct service.

GRIEVANCE PROCEDURES

The best way to resolve grievances is to prevent them, by using clear and appropriate decision-making processes and using a variety of informal methods to resolve potential problems before they become grievances. Informal methods can save time and help to build positive relationships between clients and service providers. When grievances cannot be resolved informally, formal solutions may include reliance on a specified set of written grievance procedures and/or the use of outside mediators.

Each service provider should have a written set of procedures for resolving grievances. Having a grievance process in place provides an orderly and fair process for addressing dissatisfactions early and well. A grievance process also deters individuals from airing their complaints in ways that are detrimental, such as spreading false information or escalating a complaint in a public fashion.

CLIENT'S RIGHTS AND RESPONSIBILITIES

Establishing a client's rights and responsibilities form is an excellent way to clarify expectations. It delineates what the client can expect from the service provider and what the service provider expects from the client. Below are some of the items service providers include in their Client Rights and Responsibilities form. The client and the case manager both sign and date this form. You are **not required** to use these examples, they are provided as samples that you may wish to customize to meet your agency's needs.

The client has the right to:

- Be treated with respect, compassion and sensitivity
- Receive services and benefits without discrimination of any kind
- Have all aspects of your care and services treated with privacy and confidentiality
- Have our (the service provider's) confidentiality policy explained
- Make choices about who information is released to (with some exceptions)
- Be fully informed about all of the services available
- Have grievance procedures explained
- Have complaints responded to in a timely manner with no risk of detrimental effect on services
- Refuse care and/or discontinue services at any time

The client has the responsibility to:

- To treat agency staff and volunteers with respect and to refrain from abusive language and behavior in communicating with them
- Be an active participant in obtaining services and maintaining your own well being
- Notify us (the service provider) of any change to your address, phone number, your health, financial or living situation
- Apply for all eligible benefits in 30 days
- Keep appointments or cancel in advance
- Respect the confidentiality of others
- Provide adequate information to insure appropriate services

- Provide feedback about the effectiveness of services from _____ (the service provider)
- Bring any complaint or grievance to the attention of the case manager
- Treat staff and volunteers with respect
- Allow your chart to be reviewed by the administrative agent to ensure that services are being provided and vouchers are being paid according to the standards set by _____ (the service provider)

CLIENT RECORDS/CONFIDENTIALITY

Service providers should complete and maintain accurate client records. Client information should be kept in the client's file and periodically updated. Client files must be kept for a minimum of three years following the date of final payment authorization.

Any record containing medical information with personal identifiers is considered a medical record. All medical records are confidential and must be secured as required by the Federal and State regulations (Federal Health and Safety Code Title 42 and California Code of Regulations, Title II). A copy of the Federal Health and Safety Code Title 42 may be obtained on the internet at http://www4.law.cornell.edu/uscode/42/ch6A.html. To obtain a copy of the California Code of Regulations, Title II, contact West Group, Barclays Division, P.O. Box 95767, Chicago, IL 60694, (800) 888-3600.

DATA REPORTING

OA as grantee for Consortia Program funding, must comply with HRSA reporting requirements. Fiscal agents are, therefore, required to submit reports, in a timely manner, to the OA. Failure to submit these reports by the due date may result in a 10 percent reduction of administrative monies. Fiscal agents receive their data from service providers. Therefore, it is crucial that service providers supply accurate data and in a timely fashion. The reports fiscal agents are required to complete are:

Report	Due Date(s)
Mid-Year and Year-End Reports	Mid-Year – 11/15 Year-End – 6/15
Annual Administrative Report (AAR)	12-month report (Jan. – Dec) – 2/15

Mid-Year and Year-End Reports

The two components of the mid-year and year-end reports are:

1. Financial Status Report

   The fiscal agent lists on the form (Exhibit 8*):
   - each service provider
   - total dollars allocated to each service provider
   - dollars expended to date
   - remaining balance
   - percentage expended
   - number of unduplicated clients served
   - total dollars allocated to each service provider for HIV/AIDS infected women, infants, children and youth
   - amount expended to date
   - remaining balance

   *If you would like a copy of the form formatted in Excel, contact Estella Kile, Fiscal Analyst at (916) 327-6771.

2. Narrative Report
   The Narrative Report provides an opportunity for the fiscal agent to describe the progress made in achieving the administrative and service delivery goals and objectives outlined in the application and identify any technical assistance needs.

Annual Administrative Report (AAR)

The AAR report consists of client and service data collected by the fiscal agent throughout the year.

Due Date	Data Collection Period
February 15	January 1 through December 31

The Ryan White Contract period is April 1 through March 31. The AAR report, due February 15, is a twelve-month report which consists of data collected from the previous contract year January through March and the current contract year April 1 through December 30. Please see Exhibit 10 for a sample of the AAR forms and instructions for completion. If you would like a copy of the Annual Administrative Report (AAR) Guidance Manual please contact Denise Absher, Office of AIDS, at (916) 322-3150.

Data Elements

The data elements included in the AAR are listed below. Fiscal agents, through the contract with the OA agree to comply with future data requirements developed by the federal program staff and the State.

Annual Administrative Report (AAR)
Data Elements

I. Provider Agency Contact Information
   1. Provider Name
   2. Provider Address
   3. Provider AAR Contact Name, Title, Phone Number, Fax Number, and E-Mail Address
   4. Reporting Period
   5. Type of Agency Completing the Report
   6. Reporting Scope

II. Program Information
   1. Grantee ID # (0600 – All California Title II providers have the same grantee number)
   2. Provider Number
   3. Provider Taxpayer ID #
   4. Zip Code of Principal Provider Site
   5. Total Number of Provider Sites
   6. Provider Type
   7. Ownership Status
   8. Racial/Ethnic Constitution of Board and Racial/Ethnic Constitution of Professional Staff
   9. Total Paid Full Time Equivalents (FTEs)
   10. Total Volunteer Staff FTEs

III. Client Information/Demographics
   1. Total Number of Unduplicated Clients During the Reporting Period
   2. Total Number of New Clients Served in During the Reporting Period
   3. Gender Distribution of Clients
   4. Racial/Ethnic Distribution of Clients
   5. Age Distribution of Clients
   6. HIV/AIDS Status (Percent of HIV+ Clients not Diagnosed with AIDS; Percent of HIV+ Clients Diagnosed with AIDS)
   7. Primary Exposure Category

IV. Services Provided/Clients Served
   1. Medical Services: Total number of clients receiving services AND total number of office visits for the services received for the following services:
      a.) Medical Care
      b.) Dental Care
      c.) Mental Health Treatment/Therapy or Counseling

d.) Substance Abuse Treatment/Counseling
e.) Face-to-Face Case Management
f.) Other Case Management (not face-to-face)
g.) Rehabilitation
h.) Home Health Paraprofessional Care
i.) Home Health Professional Care
j.) Home Health Specialized Care

2. Support Services: Total number of clients receiving the following services:
   a.) Residential or In-Home Hospice Care
   b.) Buddy/Companion Service
   c.) Client Advocacy
   d.) Day/Respite Care
   e.) Emergency Financial Assistance
   f.) Housing Assistance
   g.) Food Bank/Home Delivered Meals
   h.) Transportation Services
   i.) Service Outreach/Secondary Prevention Counseling
   j.) Other Counseling (not mental health)
   k.) Permanency Planning
   l.) Other Services

V. Fiscal Information
   1. Annual HIV/AIDS Funding for (HIV/AIDS program):
   a.) Title I CARE Act Funding
   b.) Title II CARE Act Funding
   c.) Other CARE Act Funding
   d.) Expenditures for medications not reported on a state or local AIDS Pharmaceutical Assistance Annual Administrative Report

VI. Fee-for-Service Providers (if applicable)
   1. Number of Fee-for-Service Providers for Whom You are Submitting Data
   2. Type of Provider
   3. Ownership Status
   4. Racial/Ethnic Constitution of Board and Racial/Ethnic Constitution of Professional Staff for Fee-for-Service Providers

Data Collection Options

The fiscal agent will determine which of the following options will be utilized.

- Ryan White CAREWare: This software is supported and supplied free of charge by HRSA. For more information, please contact John Milberg at (301) 443-8729.
- Continue with your current data collection system provided that the system is Y2K compliant and meets HRSA's specifications for submitting files electronically. TOOLBOX software, which many fiscal agents utilized, is not Y2K compliant.

- Office of AIDS data collection software program. This program consolidates data from both the Case Management Program (CMP) and the Ryan White Title II Consortia Program. For more information, please contact Denise Absher at (916) 322-3150.
- Scannable Form: You may submit data utilizing a scannable form provided by HRSA. Data must be submitted on the original HRSA form, it may not be copied. The scannable forms are available in January. For more information, please contact Denise Absher at (916) 322-3150.

CHAPTER SIX

HIV CARE CONSORTIA: ROLES AND RESPONSIBILITIES

INTENT OF HIV CARE CONSORTIA

A Consortium is an association of one or more public, and one or more nonprofit private health care and support service providers and community-based organizations, community individuals, and individuals infected and affected by HIV/AIDS. The Consortium analyzes gaps in medical and support services in its area and develops a comprehensive plan to address these gaps.

Public input is vital to the success of the Consortia Program. DHS experience indicates that active, substantive, ongoing involvement of PLWHs as members of consortia is one of the most important requirements for successful planning and implementation of the Consortia Program.

CONSORTIA STRUCTURE

Policies and Procedures

Each Consortium develops, amends, and implements policies and procedures, which are referred to by some Consortia as by-laws. Consortia policies and procedures must be submitted to the OA for approval. Any amendments to the policies and procedures must also be submitted to the OA for approval. Policies and procedures typically include guidelines regarding:

- Process for becoming a voting member
- Membership, including terms, compensation, duties, liability, vacancies
- Meetings, including location, frequency, notices, quorum, conduct,
- Election of officers, including powers and duties
- Committees, including duties, qualifications for membership, recommended membership
- Relationship to Fiscal Agent, including division of power, conflict resolution
- Consortium records, including maintenance, members' inspection rights, public access
- Amendment of policy and procedures, including steps to amend and suspend

Officers

The Consortium elects officers to serve for a period of time defined in their policy and procedures. The offices elected are typically chair or in some cases co-chairs, vice Chair, secretary, and treasurer. Consortia may establish subcommittees such as, executive committee, planning committee, membership committee, finance committee, and oversight committee.

New Members

People living with HIV disease and other community members have special orientation and training needs. They are likely to know more than other members about particular populations affected by the AIDS epidemic, and to have first-hand experience with service providers. They offer an essential perspective on service needs and the continuum of care. Special attention to new member orientation is essential to ensure encouragement and support for full participation as Consortia members. Some suggestions for new-member orientation are to provide:

- A mentoring system to help members feel welcome, learn about individual member perspectives, and become comfortable with the Consortia processes and interaction.
- Initial orientation prior to each new member's first meeting. This includes:
  - a practical orientation to their roles and responsibilities as members
  - the workplan and timeline of the topics to be addressed at the next meeting
  - Consortia structure and policies and procedures
- "Debriefing" with new members after their first meeting, so they are comfortable asking questions about the process.
- Ensure further training to provide the technical knowledge and skills needed for full participation in the Consortia's activities.
- Allow for training that addresses individual needs. For example, address the problem of burnout, helping new members make realistic time commitments and avoid becoming over-committed.
- Provide orientation and training for all new members, not just PLWHs.

HRSA has an excellent training guide called A Resource for Orienting and Training Planning Council and Consortium Members. To obtain a copy of this manual, contact the HRSA Information Center at (888) ASK-HRSA.

Subcommittees

The fiscal agent is responsible, via a contractual agreement with the OA, for financial expenditures and oversight of the administration of the Consortia Program in their designated area. The Fiscal Agent or a representative must be present at all Consortia meetings. OA requires the Fiscal Agent be a member of the executive and finance committee if they are established.

Meetings

All consortia meetings must follow the Ralph M. Brown Act. This act is the law that guarantees the public's right to attend and participate in meetings of local legislative bodies. The Act contains topics such as: purpose and scope, bodies covered by the Act, the definition of a meeting and specific issues and formats of meetings, notice and agenda requirements, rights of the public, permissible closed sessions, and penalties and remedies for violation of the Act. To receive a copy of the Act, contact the Attorney General's Office, Public Inquiry Unit, P.O. Box 944255, Sacramento, CA 94244-2550, (800) 952-5225.

In order for a Consortium to meet as a decision-making body, a quorum must be present. The Brown Act defines a meeting or "quorum" as, "any congregation of a majority of the members of a legislative body at the same time and place to hear, discuss or deliberate upon any matter which is under the subject matter jurisdiction of the agency."

CONSORTIA MEMBERSHIP REQUIREMENTS

Any member of a community, who is interested and lives within geographical area served by the Consortium, may become a member of the Consortium. The following table lists the required and recommended membership for a consortium. Each consortium develops policies and procedures which are submitted to the State Office of AIDS for approval. The policies and procedures may contain membership guidelines in addition to those listed below.

Required Membership	Agencies	• Non profit, private community-based organizations* • Local health departments* • Local public health tuberculosis controllers • Mental health provider • Social service provider • Substance abuse provider • Community health care clinics • Cities or other jurisdictions or special districts providing HIV services • Agencies receiving HIV testing and early intervention funds • Non-elected community leaders • Local governmental or non-profit housing agencies
	Affected Communities	• Physically disabled • Visually or hearing impaired • Mentally ill • Developmentally disabled • Gays and lesbians • Homeless (including local housing agents) • Hemophiliacs • Representatives for the incarcerated • Women • Advocates for new immigrants and undocumented persons • Children and adolescents • Gay men of color • Substance abusers • Ethnic groups including: Latino, African Americans, Asians, Pacific Islanders, Native American
	Individuals	• Persons with HIV and their advocates*
Recommended Membership		• Non-profit, health care and support service providers and CBO's Volunteer groups

		• Persons receiving assistance through CalWORKS and/or WIC • Representatives of: ➢ Hospitals ➢ HRSA-supported Pediatric Demonstration Projects ➢ Counseling and testing programs funded by the National Centers for Disease Control ➢ Federal HIV/AIDS primary care and substance abuse programs ➢ "Healthy Start" programs ➢ Legal assistance agencies ➢ Local county substance abuse program offices ➢ Title III(b) Early Intervention Projects ➢ Projects funded under HOPWA ➢ HRSA-funded AIDS Education and Training Center Programs (AETC) ➢ Special Projects of National Significance (SPNS) ➢ Representatives from Title I Eligible Metropolitan Area Planning Council

*Non-waiveable membership, the consortium must include members in these three categories.

Voting Membership

All voting members of a consortium must complete a Statement of Economic Interests (Form 700) annually. New members must complete a Form 700 before voting as a member of the Consortium. This form must also be completed upon a member's resignation from the Consortium. Members must disclose any reportable investments and interests held by themselves or immediate family as described in the application guidelines. Failure to complete and submit Form 700 annually or upon resignation of membership may result in a referral to the Commission's Enforcement Division and a minimum fine of $200 - $300. (See **Conflict of Interest** for more information on Form 700.)

Consortia may develop policies limiting the voting membership for support and health care service providers, representatives of agencies, affected communities, etc. Consortia may not limit the voting membership of individuals with HIV and their advocates.

CONSORTIA TASKS

The consortia is required to:

- Conduct or update an assessment of HIV/AIDS service needs for the geographic service area
- Establish a service delivery plan based upon prioritized services
- Coordinate and integrate the delivery of HIV related services
- Assure the provision of comprehensive outpatient health and support services
- Evaluate the Consortium's success in responding to service needs
- Evaluate the cost-effectiveness of the mechanisms used to deliver comprehensive care

The following table is a brief, general guide of consortia activities.

April 1 – May 30	Review the past year's needs assessment process, determine who and how the needs assessment process will be conducted, and revise assessment tools as appropriate.
June 1 – August 31	Conduct needs assessment and develop criteria for allocation.
September 1 – November 30	Prioritize data received from the needs assessment process, establish a plan to ensure the delivery of services to meet the needs identified, determine the allocation to service categories, provide this information to the fiscal agent.
December 1 – February 1	Fiscal agent prepares and conducts RFP process for selection of service providers.
February 1 – February 15	Fiscal agent and consortium complete and submit annual application to OA.
February 10 – March 31	Consortium evaluates how they function and identifies any barriers to having an effective organization. Fiscal agent and consortium respond to any concerns addressed in application review letter from OA.

Application

In order for a fiscal agent to receive funds from the OA to implement the Consortia Program, the fiscal agent must prepare and submit an annual application to OA. The OA prepares and transmits, usually in November, an application package to fiscal agents and Consortia chairpersons. The package includes guidelines on how to complete the application, forms to be utilized, a list of services that may be funded, goals for the upcoming year, and a list of consortia liaisons and their assigned areas.

The application includes assurances the consortium will:

- Conduct or update an assessment of HIV/AIDS service needs for the geographic service area,
- Establish a service delivery plan based upon prioritized services,
- Coordinate and integrate the delivery of HIV-related services,
- Assure the provision of comprehensive outpatient health and support services,
- Evaluate the Consortium's success in responding to service needs, and
- Evaluate the cost-effectiveness of the mechanisms used to deliver comprehensive care.

Needs Assessment

The legislation for Title II specifically requires Consortia to conduct a needs assessment. In areas where there are no Consortia, the Fiscal Agent, utilizing an advisory group, conducts a needs assessment.

Needs assessment is a process of collecting information about the needs of persons living with HIV (PLWH) (both those receiving care and those not in care), identifying current resources (CARE Act and other) available to meet those needs, and determining what

gaps in care exist. This requires obtaining information from multiple sources about current conditions – including problems/service needs and the resources/approaches being used to address these needs. Presented overall and for specific populations, findings should be used to prioritize service needs and develop strategies to address them.

CARE Act services are intended to fill gaps in care for PLWH, including assisting individuals to access and remain in care. CARE Act needs assessment identifies service gaps by reviewing the current continuum of care, access to care for affected populations, particular service issues such as the quality of care and barriers to care, and areas of unmet need. Key needs assessment tasks include:

- Identifying the HIV/AIDS client base, through an array of epidemiologic, co-morbidity, and socioeconomic data as well as other needs assessment information obtained through such methods as surveys, focus groups, and individual interviews. This information can reveal who is impacted by HIV/AIDS, their characteristics and needs, and access to health care through public and private health insurance;
- Identifying existing services available to PLWH through a resource inventory of available services and organizations and an assessment of provider capacity/capability to deliver HIV/AIDS care; and
- Identifying gaps in service needs that CARE Act programs might address. These are revealed by comparing available services to identified needs, including analysis that results in identification of particular service needs for specific PLWH populations. Identification of unmet needs should examine, in particular, gaps in care for asymptomatic PLWH, individuals with symptomatic HIV disease and a generally higher level of service needs, and individuals who are infected but do not yet know their HIV status.

The results of a needs assessment are used by CARE Act planning bodies and fiscal agents to meet their legislative responsibilities and help ensure that available CARE Act dollars are used effectively. This includes:

- Establishing service priorities;
- Providing guidance on how best to meet these priorities;
- Doing comprehensive planning for a continuum of care;
- Documenting the need for specific services and gaps in care;
- Providing baseline data for evaluation; and
- Helping providers improve service access and quality.

Needs assessment is the cornerstone of the CARE Act planning process. Needs assessment provides the information required to develop a service plan, set priorities, and allocate available resources appropriately.

HRSA developed a Needs Assessment Guide to assist the CARE Act community in planning and conducting needs assessment. To request a copy of this manual call HRSA at (888) ASK-HRSA (888) 275-4227 or visit their website at www.hrsa.gov/hab.

A variety of resources to aid consortia and fiscal agents in the community planning process are available on the HAB web site. Included on the site is a page on assessing unmet need, a new focus for the CARE Act 2000. To access these planning resources go

to: http://hab.hrsa.gov/tools.html. Use the pull-down menu to go to "Planning/Needs Assessment."

HRSA's HIV/AIDS Bureau (HAB) sends via e-mail, technical assistance and primary care updates for the CARE Act community. To subscribe, contact Paula Jones at pjones1@hrsa.gov.

CONFLICT OF INTEREST

HRSA defines conflict of interest as "an actual or perceived interest by a member in an action which results in, or has the appearance of resulting in, personal, organizational, or professional gain."

Any action which could be seen as an attempt to influence the process for personal, organizational, or professional gain should be included in the consortium's definitions of conflict of interest. Many consortia members, in addition to serving on the consortia, are often affiliated with other organizations, either as an employee, a member, a board member, or a volunteer.

When joining a consortium, members should be asked to complete a Conflict of Interest statement on which they list all organizations with which they are involved. Members need to be sure they have a thorough understanding of the conflict of interest guidelines for any consortia that they currently belong to or will join in the future.

The potential for conflict of interest is present in all Ryan White planning processes. To minimize the negative impact of conflict of interest, planning processes must be open, public, and based on clear policies. Consortia should have the following in place, at a minimum:

- A definition of conflict of interest
- A method of disclosure of conflict of interest
- A duration that a conflict of interest disclosure is effective, and
- A method or methods of resolution when a conflict of interest action arises that violates the group's policies and procedures.

Form 700 - Statement of Economic Interests

The Fair Political Practices Commission (FPPC) requires consortium members complete a Form 700 because they are in a position that entails the making or participation in the making of governmental decisions which may foreseeably have a material effect on any financial interest. Please contact the fiscal agent for information on obtaining and completing a Form 700. Making a governmental decision means a person: (1) votes on a matter; (2) appoints a person; (3) obligates or commits his or her agency to any course of action; or (4) enters into any contractual agreement on behalf of his or her agency. Participating in the making of a decision, means a person: (1) negotiates, without significant substantive review, with a governmental entity or private person regarding the decision; or (2) advises or makes recommendations to the decision-maker by conducting research or an investigation, preparing or presenting a report, analysis or opinion which

requires the exercise of judgment on the part of the employee and the employee is attempting to influence the decision.

In single county consortia, the Form 700 is kept on file at the County Clerk's office. In multiple county consortia, where the Form 700 is filed is stipulated in the conflict of interest code adopted by the consortia. The completed Form 700 is considered public information and may be viewed by the public or a copy provided to the public upon request.

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OFFICE OF AIDS
HIV Care Consortia

Management Memorandum
Memorandum Number: 01-01

To: **Program Fiscal Agents**
Consortia Chairs
Services Providers

Date: January 16, 2001

Topic: **Notification of Administrative Revisions to Consortia**

The Ryan White CARE Act is entering its eleventh year – the first year after the most recent reauthorization. The revised CARE Act language provides guidance regarding Health Resources Services Administration (HRSA)'s fundamental principals, a priority for the provision of primary medical care, access to primary medical care, and the provision of quality HIV care. This focus and guidance provides an opportunity to affect positive change within the existing system of HIV care. Clearly, we are facing myriad challenges throughout the next few years as we address the changing requirements of HRSA and the state system, and most importantly the needs of our clients.

To prepare for changes related to addressing HRSA's fundamental principals the statewide California HIV Planning Group (CHPG) recommended revisions to the approach utilized to allocate Consortia Program resources. The Office of AIDS (OA), in accepting CHPG's recommendation, recognized that measures to streamline and reduce administrative processes were also required at this time.

The OA is committed to implementation of these changes in a manner that also addresses various administrative and programmatic concerns voiced by fiscal agents, consortia members, clients and service providers. We will begin implementing these changes effective Year 11.

CHPG's recommendation and the resulting changes to the allocation of Consortia Program funds and program administration is further clarified in this management memo.

Tiered Approach

HIV service needs and resources vary significantly in a state as geographically, culturally and economically diverse as California. Service needs of existing and emerging populations, cultural issues, administrative capacity, technical assistance needs, and available funding differs greatly throughout the state; it's imperative that the Consortia Program address these changing needs by maintaining the flexibility needed to address service needs in these varying local environments.
The OA developed a tiered approach to begin addressing two areas of concern identified by various fiscal agents and consortia -- increased administrative responsibilities and imbalanced funding levels. These issues have been addressed through the development of

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http://www.consumerenergycenter.org/flex/index.html

three categories, or tiers, of counties where funding levels, as well as administrative responsibilities, will be established at a level commensurate with local needs and utilization.

Tier A: ***Tier A counties are identified as counties with six or fewer Persons Living With AIDS (PLWA) or persons served. Tier A counties will be subject to administrative and funding revisions, as detailed in this management memo. The following counties are in Tier A:***

Alpine
Colusa
Del Norte
Glenn
Inyo
Modoc
Mono
Plumas
Sierra

Tier B: ***Tier B counties are those counties significantly impacted by increased demand for services, as demonstrated through caseload data, increasing persons accessing services, increasing PLWA, decreasing Title II Consortia Program funding, and per capita HIV/AIDS funding that falls below the statewide average. Tier B counties will be subject to funding and administrative revisions as detailed in this management memo. The following counties are in the Tier B category:***

Fresno
Kern
Monterey
Santa Cruz
Solano
Stanislaus

Tier C: ***Tier C counties are those Eligible Metropolitan Area (EMA) and non-EMA counties that do not fall into Tiers A or B, and will not be subject to funding or significant administrative revisions in Year 11.***

Administrative Responsibilities

Administrative requirements are being reduced or streamlined where possible in response to contractors' concerns regarding the administrative responsibilities associated with the Consortia Program, especially by contractors with relatively small administrative allocations. The OA acknowledges the difficulties experienced by Tier A contractors in complying with state and federal administrative processes and is developing minimal administrative standards for these counties.

An administrative manual is being finalizing that provides guidance to fiscal agents and subcontracting agencies in the administration of the Consortia Program. Consortia staff will be available to provide ongoing technical assistance as we progress through implementation of these revisions.

Direct Service Contracting

During the last quarter of Year 09, seven counties underwent a disbanding of their HIV Care Consortia. Of primary importance was the provision of HIV services to the persons living with HIV/AIDS in these impacted counties; this was addressed through implementation of the Direct Services pilot. HRSA approved utilization of the Direct Services category of the CARE Act, which allows states to directly fund services in the absence of a consortium or when this approach is proven to be more beneficial to the delivery of services. Under this pilot, the OA directly contracted with local fiscal agents that provide or subcontract HIV services. Fiscal agents are solely responsible for the completion of planning documents and other documents typically required of consortia. Though not required under the Direct Services category, the OA values the importance of public input in development of local care plans and mandated that each fiscal agent periodically convene an advisory group to assist in the development of planning documents, as needed.

The Direct Services Pilot Program is currently being evaluated, and to date has proven to be an efficient model in the absence of a consortium, or for consortia that are unable to complete assigned tasks, such as the development of needs and other planning documents.

To limit administrative burden and expenses, Tier A counties may utilize the Direct Services approach to the delivery of HIV services in Year 11. During Year 11, the OA will complete evaluation of this model and determine if this model will be offered to the balance of the state's HIV Care Consortia Program. Non-EMA multi-county regions that include Tier A counties are provided the option to utilize the Direct Services or Consortia model.

Resource Allocation

Funding for the Consortia Program has been allocated to counties on a formula basis, which is based primarily upon the total persons living with AIDS in each county. The allocations have also been subject to a 95 percent hold harmless provision that was developed to protect counties from receiving large funding decreases resulting solely through utilization of the formula.

The CHPG makes recommendations to the OA regarding the process for allocating Consortia Program funds. The CHPG recently determined that certain counties have experienced dramatic increases in the number of clients served, while disproportionately larger allocations have been made to counties with relatively few clients. The allocation process has created funding imbalances and has not kept pace with the needs of counties experiencing dramatic increases in service needs. The CHPG recommended that, due to these imbalances and HRSA's emphasis on access to HIV services, the allocation process be revised.

Revised Approach to Resource Allocation

The OA accepted CHPG's recommendation to develop a tiered approach to the allocation of Consortia Program resources. This revision will be phased in throughout program Years 11 and 12. Of particular importance to creation of this model was the need to determine the number of persons accessing services in each county. AIDS Drug Assistance Program and Medi-Cal data, which provided the number of persons per county accessing those two programs for HIV medications, were considered to be the most reliable indicators currently available for determining the number of eligible persons accessing HIV services in each county.

Revision No. 1:

OA will use the existing formula, but will implement the CHPG recommendation to remove the PLWA numbers representing the incarcerated population (primarily the population residing in state correctional facilities) from the data representing the total PLWA per county. These data are collected and reported to the Centers for Disease Control and Prevention, but will not be utilized in allocating Consortia Program funding.

Revision No. 2:

The OA has developed a phased, two-year approach to revising the resource allocation process that is based upon the number of persons served, the number of PLWA and HIV funding sources available per county. This tiered approach will address funding imbalances by providing decreased funding to counties with lower service needs (Tier A), while redirecting funds to the counties with increasing service unmet need (Tier B).

Tier A allocations:

Tier A counties will receive a Year 11 allocation based upon the higher of the following:

a) statewide HIV funding average per capita ($4175)
b) formula allocation (not subject to 95 percent hold harmless)
c) established Year 11 floor of $30,000

Tier A counties will receive a Year 12 allocated based upon the higher of the following:

a) statewide HIV funding average per capita (to be determined)
b) formula allocation (not subject to 95 percent hold harmless)
c) established Year 12 floor of $15,000

Tier B allocations:

Tier B counties will receive an allocation based upon the formula.

In addition, Tier B counties will receive a pro rata augmentation of Consortia Program funds in Program Years 11 and 12.

Tier C allocations:

Tier C counties will receive an allocation based upon the formula.

Based upon CHPG's recommendation, the OA is implementing a two-year funding allocation process based upon HIV service needs in each county. Client level data provides a clear overview of local service needs and allows for the allocation of Consortia Program funding to be equitably based upon this need.

Please do not hesitate to contact your Consortia Liaison to discuss these program and fiscal changes.

Thank you for your ongoing commitment to the provision of HIV services in California.

Sincerely,

Peg Taylor, Chief
CARE Section
Office of AIDS

Consortia Liaisons:

Jeff Byers	Liz Voelkert	Leona Lucchetti	Cynthia Garey
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OFFICE OF AIDS
HIV Care Consortia

Management Memorandum
Memorandum Number: 01-02

To: Title II Fiscal Agents **Date: January 12, 2001**

Subject Ryan White CARE Act Application 2001-02 (Year 11)

Enclosed is the Ryan White CARE Act Application for Fiscal Year 2001-02 and the Technical Assistance Manual.

HRSA Emphasis

The fiscal year 2001 grant application guidance received by the Office of AIDS from the Health Services and Resources Administration (HRSA) identified several areas of emphasis. They are:

- Continue to develop systems that support 100% access to medical treatment and 0% disparity in health outcomes among under-served and emerging populations.
- Ensure that primary medical care is available to all individuals.
- Increase efforts to bring infected individuals not in care, into care.
- Provide outcome evaluation data to HRSA to meet legislative requirements and provide states with data about service effectiveness.
- Clearly indicate how support services help individuals access or maintain participation in primary medical care.

Service Category Changes

To achieve the above emphasis, HRSA added, changed or deleted several service categories. In brief, major changes include:

- Primary medical care has been defined to include care that is consistent with Public Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
- Chiropractic and acupuncture treatments can be provided when approved in writing by an individual's primary care physician.
- All other "complimentary therapies" are no longer allowable, including massage, Chinese herbs, etc.

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- Case management services have been moved from “health services” to “support services.” Additionally there is increased need to differentiate among case management, client advocacy and referral services.
- A new category of “HIV/AIDS Treatment Adherence” is created; guidance for this category has not been received from HRSA.

Housing and Utility Assistance Coordination Between RWCA and HOPWA

Ryan White Title II funds for housing assistance are restricted as stated below; the Housing Opportunities for People With AIDS program (HOPWA) does **not** contain these restrictions.

- Only short term or emergency housing is allowable;
- Housing assistance must meet the “payor of last resort” test;
- CARE assistance cannot be for permanent housing. Short term housing assistance must include a plan to identify, locate, and ensure that the family is moved to permanent housing; and
- Housing assistance must be linked to medical and/or supportive services or be certified as essential to a client’s ability to gain or maintain access to HIV–related medical care or treatment.

This year, HOPWA will be making a concerted effort to spend the maximum amount of funding possible for direct housing and utility costs. Housing related services provided by Ryan White Title II must be evaluated to determine what portion of the services could be paid using HOPWA funds versus Ryan White Title II funds. Expenditures that may require extensive documentation and/or justification under Ryan White Title II are routine under HOPWA. It is imperative that you evaluate these issues when developing your Ryan White Title II application. Once evaluated, shift services to HOPWA or Ryan White as appropriate.

Review your proposed service categories to determine:

- The amount of staff costs currently paid with HOPWA funds which could be paid for by Ryan White Title II.
- Direct housing services allocated under Ryan White Title II which could be paid for with HOPWA funds.
- That coordinated planning efforts for these (and other) housing funding sources exist.

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Office of AIDS Activities

To help the State and Consortia support HRSA's goals, the Office of AIDS took several steps during the past years, including:

- Provided goals and objectives to the consortium to facilitate their movement towards the goals of 100% access/0% disparity.
- Provided to fiscal agents, consortia members, service providers and OA office staff training in unit costing and outcome evaluation, which are required activities.
- Streamlined the annual application where possible.
- Provided technical assistance to individual Consortia as requested.
- Created a direct contract option for counties whose Consortia disbanded.
- Released low-impact counties from administrative requirements where possible.
- Increased technical assistance to high-impact counties.

2001 – 2002 Application

The reauthorized Ryan White CARE Act contains numerous revisions and clarifications regarding the utilization of Title II funds, many of which require program and administrative revisions at the state and local levels. The OA has begun development of a preliminary implementation plan for addressing and meeting HRSA's goals and objectives; many of the program revisions contained within this application are a direct outcome of the OA's implementation plan.

A simplified application process for Year 11 has been created. The initial application submittals are minimal, and include primarily budget and administrative documents and certifications. A follow-up submittal will detail local efforts being planned for addressing HRSA's emphasis on increasing access to medical treatment and decreasing disparities in health outcomes.

Consortia and Direct Services Contractors must utilize this time to restructure their activities and programs to reflect HRSA's emphasis on increasing access to medical treatment and decreasing disparities in health outcomes. Services funded by Ryan White Title II in Year 11 (FY 2001/02) must be necessary for clients to access or maintain access to primary medical care. The plans you developed to identify and bring under-represented populations into service will be critical to meeting HRSA's goals. If you need technical assistance in refining your plans, including identifying populations, please contact your liaison.

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Allocations

Due to the Act's reauthorization and recent political events, HRSA has not received confirmation on the funding allocations for the coming year. You will be notified as soon as possible as to the amount of funding for fiscal year 2001-02.

Peg Taylor, Chief
CARE Section

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OFFICE OF AIDS
HIV Care Consortia

Management Memorandum
Memorandum Number: 01-03

TO: Title I Contacts for Title II Contracts **DATE:** January 11, 2001

Topic Consortia Program Application for Fiscal Year 2001- 2002 (Year 11)

Summary Attached is the Consortia Program Application for Fiscal Year 2001 - 2002. We incorporated new elements based upon information received from the Department of Health and Human Services (HRSA) HIV/AIDS Bureau (HAB) and subsequently made changes in the narrative portion and in the fiscal documents.

To apply for Ryan White Title II Care Act Consortia Funds, complete the attached checklist, fiscal documents and attach a copy of your 2001 Title I Formula/ Supplemental application that was submitted to HRSA in September, 2000.

Due Date Complete and submit your application no later than Wednesday, February 8, close of business. FAX copies will not be accepted.

Peg Taylor, Chief
CARE Section

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Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

OFFICE OF AIDS
Care Services Program

Management Memorandum
Memorandum Number: 02-05

TO: **CARE SERVICES PROGRAM FISCAL AGENTS**

DATE: March 28, 2002

Topic **Care Services Program Allocation for Fiscal Year 2002 (Year 12)**

Enclosed is the Care Services Program Allocation Table for Program Year 12 (Fiscal Year 2002/03), dated March 28, 2002. In reviewing the allocation information, please note the following:

Resource Allocation Process

Funding for the Care Services Program has been allocated to counties on a formula basis, which is based primarily upon the total persons living with AIDS in each county. The allocations have also been subject to a 95 percent hold harmless provision that was developed to protect counties from receiving large funding decreases resulting solely through utilization of the formula.

The Resource Allocation Committee of the statewide California HIV Planning Group (CHPG) makes recommendations to the Office of AIDS (OA) regarding the process for allocation Care Services Program funds. The CHPG recently determined that certain counties have experienced dramatic increases in the number of clients served, while disproportionately larger allocations have been made to counties with relatively few clients. A tiered allocation process was created, upon recommendation of the CHPG, to address these imbalances over a two year period by redirecting funding to the counties with the highest need.

Resource Allocation Revision

The Tiered Approach to resource allocation has been fully implemented (see Management Memo 01-01). Adjustments have been made to lower the funding available to existing Tier A counties and a redirection of additional funding to the highly impacted Tier B counties.

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www.consumerenergycenter.org/flex/index.html

Tier A counties:	Tier B counties:
Alpine	Fresno
Colusa	Kern
Modoc	San Joaquin
Mono	San Luis Obispo
Sierra	Stanislaus

The 95 percent hold harmless provision is still in effect and was equally applied, with the exception of existing Tier A counties.

Minimum Allocations to Women, Infants, Children, and Youth

Please note that the allocation table does not include specific requirements for Women, Infants, and Children (WIC), which has been the practice in past years. The WIC mandate was expanded in Year 11 to include Women, Infants, Children, and Youth, and requires that funds be allocated and expenditures tracked separately for each of these four categories. The Ryan White CARE Act also includes language that allows state grantees to request a waiver to all or part of this requirement. It is anticipated that the OA will request a waiver to one or all of these categories.

Thank you for your patience with the Year 12 allocation process. Our receipt of the Title II allocation information from Health Resources Services Administration was delayed, and our process for developing the final allocation was further delayed due to unforeseen problems in receiving data.

If we can be of assistance to you, please do not hesitate to contact your Care Services Program Advisor or the Care Services Program Fiscal Analyst, Stella Kile at (916) 327-6771.

Peg Taylor, Chief
CARE Section
Office of AIDS

Enclosure

Care Services Program Advisors:

Barbara Weiss	Liz Voelkert	Leona Lucchetti	Cynthia Garey	Stella Kile
(916) 323-3740	(916) 327-6792	(916) 445-1180	(916) 324-1161	(916) 327-6771

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 323-8949

OFFICE OF AIDS
HIV Care Consortia

Management Memorandum
Memorandum Number: 01-04

Management Memorandum No. 01-04 was not released.

DEPARTMENT OF HEALTH SERVICES
OFFICE OF AIDS
611 NORTH SEVENTH STREET, SUITE A
SACRAMENTO, CA 95814-0208

OFFICE OF AIDS
HIV Care Consortia

Management Memorandum
Memorandum Number: 01-05

TO: **Consortia Program Fiscal Agents** **DATE: March 16, 2001**

Topic **Consortia Program Allocation for Fiscal Year 2001- 2002 (Year 11)**

Summary

Enclosed is the Consortia Program Allocation Table for Program Year 11 (Fiscal Year 2001/2002), dated March 14, 2001. In reviewing the allocation information, please note the following:

Funding Decreases: The Year 11 Consortia Program allocation has been reduced by $459,069. This funding decrease impacted the State's Title II allocation and was the result of new provisions of the reauthorized Ryan White CARE Act (RWCA), to include a set-aside earmarked nationally for emerging communities. California joins 31 other states that experienced substantial funding decreases in their Title II allocations. Most non-Tier A counties were not impacted by this decrease due to the 95% hold harmless provision of the Consortia Program resource allocation process.

Resource Allocation Revision: The Tiered Approach to resource allocation has been fully implemented, with additional funds being redirected to the highly impacted Tier B counties. (See Management Memo 01-01 for detailed description of this change to the resource allocation process.)

Minimum Allocations to Women, Infants, Children and Youth: Please note that the allocation table does not include specific requirements for Women, Infants and Children (WIC), which has been the practice in past years. The RWCA WIC mandate has been expanded to include Women, Infants, Children and Youth (WICY), and requires that funds be allocated and expenditures tracked separately for each of these four categories. The RWCA also includes language that allows state grantees to request a waiver to all or part of this requirement.

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http://www.consumerenergycenter.org/flex/index.html

Health Resources Services Administration has not provided guidance for Title II grantees regarding the WICY requirements and the process for requesting a waiver. Until the Office of AIDS receives guidance and is able to provide clear instruction to fiscal agents regarding this requirement, fiscal agents and service providers must document expenditures for clients that fall into one of these categories for future reporting purposes. It is anticipated that guidance regarding this requirement will be made available within the next 60-days.

Your Consortia Liaison will be in contact with you regarding the revisions to your Consortia Program budget documents that may be required as a result of this allocation information.

The unforeseen delays in receiving the Title II allocation has created an administrative nightmare for all parties involved. The staff of the Consortia Program is determined to do everything possible to ensure that the clients do not experience a lapse in service delivery due to this delay.

If we can be of assistance to you, please do not hesitate to contact your Consortia Liaison or the Consortia Program Fiscal Analyst, Stella Kile at (916) 327-6771.

Peg Taylor, Chief
CARE Section

Enclosure

Consortia Liaisons:

Jeff Byers	Liz Voelkert	Leona Lucchetti	Cynthia Garey	Stella Kile
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OFFICE OF AIDS
HIV Care Consortia

Management Memorandum
Memorandum Number: MM02-01

To: **Title II Fiscal Agents** **Date: January 19, 2002**

Subject: **Consortia Program Guidance and Technical Assistance Manual, and Intent to Provide Services**

Summary:

The above listed documents are electronically attached to this management memorandum. These documents provide you with information to prepare and submit the components of your Consortia Program or Direct Services Contract program application for FY 2002 – 2003. You may submit all documents via email except those that require signatures. The budget documents have been re-formatted in Excel and self-total. If you have any questions regarding these documents, please contact your assigned consortia liaison.

The Health Resources and Services Administration (HRSA) has not released information regarding California's Title II Program allocation. We will notify you as soon as possible once we receive the Consortia Program allocation.

To the extent possible please allocate funds for consortia member training and travel. Based on input from the Consortia Model Focus Group, we are developing training and meeting opportunities. We have a limited budget for training and the Office of AIDS cannot compensate all consortia activity costs. Our hope is to provide regional trainings to lower training costs. We will provide information on training and meetings as they are developed.

Action Required

Please file this management memorandum in your Consortia Administrative Manual.

Peg Taylor, Chief
CARE Section

Consortia Liaisons:

Jeff Byers	Liz Voelkert	Leona Lucchetti	Barbara Weiss
(916) 327-6804	(916) 327-6792	(916) 445-1180	(916)232-2740

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OFFICE OF AIDS
HIV Care Consortia

Management Memorandum
Memorandum Number: 02-03

To: **Title II Fiscal Agents** **Date: March 7, 2002**

Subject: **Consortia Program Changes and Meeting**

Consortia Program Changes

California uses the HIV Care Consortia funding category of the Ryan White CARE Act to provide Title II funds for the coordination, planning and provision of HIV services. Over the past two years, several counties' consortia disbanded and others expressed concerns with consortia program requirements. We developed a pilot project using the Direct Services category to fund health and support services for the counties with no consortia. Based on the Pilot Project evaluation and recommendations from fiscal agents, consumers, community members and service providers, consortia program staff developed an alternative model to the consortia. The attached "Care Services Program" document describes this process and the new planning model.

Tier A stand-alone county requirements are not changed, however, Tier A fiscal agents should be familiar with the changes because tier status can change based on client population.

Meeting

The meeting on March 27 and 28 will:

- Explain the new model requirements and provide an opportunity for you to discuss the changes with other fiscal agents;
- Include information on creating linkages with Title III and IV projects; and,
- Provide training on "Creating Linkages Within Your Community", presented by Alice Gandelman, Director, CA STD/HIV Prevention Training Center and Paul Gibson, Director, Chlamydia Awareness Prevention Project.

Action Required

Please:

- Complete and return the fax document if you will be attending the meeting;
- Review the "Care Services Program" document prior to the meeting.
- File this management memorandum in your Consortia Administrative Manual and forward a copy to your service providers.

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

OFFICE OF AIDS
Care Services Program

Management Memorandum
Memorandum Number: 02-05

TO: **CARE SERVICES PROGRAM FISCAL AGENTS**

DATE: March 28, 2002

Topic **Care Services Program Allocation for Fiscal Year 2002 (Year 12)**

Enclosed is the Care Services Program Allocation Table for Program Year 12 (Fiscal Year 2002/03), dated March 28, 2002. In reviewing the allocation information, please note the following:

Resource Allocation Process

Funding for the Care Services Program has been allocated to counties on a formula basis, which is based primarily upon the total persons living with AIDS in each county. The allocations have also been subject to a 95 percent hold harmless provision that was developed to protect counties from receiving large funding decreases resulting solely through utilization of the formula.

The Resource Allocation Committee of the statewide California HIV Planning Group (CHPG) makes recommendations to the Office of AIDS (OA) regarding the process for allocation Care Services Program funds. The CHPG recently determined that certain counties have experienced dramatic increases in the number of clients served, while disproportionately larger allocations have been made to counties with relatively few clients. A tiered allocation process was created, upon recommendation of the CHPG, to address these imbalances over a two year period by redirecting funding to the counties with the highest need.

Resource Allocation Revision

The Tiered Approach to resource allocation has been fully implemented (see Management Memo 01-01). Adjustments have been made to lower the funding available to existing Tier A counties and a redirection of additional funding to the highly impacted Tier B counties.

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Tier A counties:	Tier B counties:
Alpine	Fresno
Colusa	Kern
Modoc	San Joaquin
Mono	San Luis Obispo
Sierra	Stanislaus

The 95 percent hold harmless provision is still in effect and was equally applied, with the exception of existing Tier A counties.

Minimum Allocations to Women, Infants, Children, and Youth

Please note that the allocation table does not include specific requirements for Women, Infants, and Children (WIC), which has been the practice in past years. The WIC mandate was expanded in Year 11 to include Women, Infants, Children, and Youth, and requires that funds be allocated and expenditures tracked separately for each of these four categories. The Ryan White CARE Act also includes language that allows state grantees to request a waiver to all or part of this requirement. It is anticipated that the OA will request a waiver to one or all of these categories.

Thank you for your patience with the Year 12 allocation process. Our receipt of the Title II allocation information from Health Resources Services Administration was delayed, and our process for developing the final allocation was further delayed due to unforeseen problems in receiving data.

If we can be of assistance to you, please do not hesitate to contact your Care Services Program Advisor or the Care Services Program Fiscal Analyst, Stella Kile at (916) 327-6771.

Peg Taylor, Chief
CARE Section
Office of AIDS

Enclosure

Care Services Program Advisors:

Barbara Weiss	Liz Voelkert	Leona Lucchetti	Cynthia Garey	Stella Kile
(916) 323-3740	(916) 327-6792	(916) 445-1180	(916) 324-1161	(916) 327-6771

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

OFFICE OF AIDS
Care Services Program

Management Memorandum
Memorandum Number: 02-06

DATE:

TO: **CARE SERVICES PROGRAM FISCAL AGENTS**

SUBJECT: **YEAR 12 CARE SERVICES PROGRAM APPLICATION DOCUMENTS AND REVISED AGREEMENTS AND ASSURANCES FORM**

Summary

Management Memo 02-05, e-mailed to you on Friday, March 29, 2002, contained the Year 12 Care Services Program Allocation Table. A hard copy of Management Memo 02-05 is being mailed to you.

Enclosed is the revised Agreements and Assurances form, which reflects the new Care Services Program model (Title I grantees do not need to complete this form).

In order to process your contract amendment and ensure ongoing payment for services, please submit all required application documents by the date noted below.

Due Date/ Questions

Please submit the Year 12 application documents to your Care Services Advisor on or before **April 19, 2002**. If you have any questions, please contact your Care Services Advisor.

Peg Taylor, Chief
CARE Section
Office of AIDS

Enclosures

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State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

OFFICE OF AIDS
Care Services Program

Management Memorandum
Memorandum Number: 02-07

DATE:

TO: **NON-EMA CARE SERVICES PROGRAM FISCAL AGENTS**

SUBJECT: **ADDITIONAL INFORMATION FOLLOWING THE MARCH 27, 2002 NEW MODEL MEETING**

Summary

Enclosed are several pieces of information requested at the March 27, 2002.

New Model meeting at the Office of AIDS. The information includes:

- DHS Office of Legal Services decision regarding the FPPC Form 700 and the Brown Act
- Definition of "consult with"
- Transition Plan information and forms
- List of barriers identified by infected/affected community members at the focus group held in October 2002 to discuss the consortia model
- Peg Taylor's power point presentation of the new Care Services Program model

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Due Date

The transition plan is due to your Care Services Program Advisor by **July 1, 2002**.

Questions

Please contact your Care Services Program Advisor if you have any questions.

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Peg Taylor, Chief
CARE Section
Office of AIDS

Enclosures

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

OFFICE OF AIDS
Care Services Program

Management Memorandum
Memorandum Number: 02-08

DATE:

TO: **ALL CARE SERVICES PROGRAM FISCAL AGENTS**

SUBJECT: **NEW MILEAGE REIMBURSEMENT RATE**

Summary The State of California mileage reimbursement rate has increased from $.31 per mile to $.34 per mile. Effective April 1, 2002, mileage will be reimbursed up to $.34 per mile.

Action Required Please file this Management Memorandum in your Program Administrative Manual.

Questions Please contact your Care Services Program Advisor if you have any questions.

Peg Taylor, Chief
CARE Section
Office of AIDS

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www.consumerenergycenter.org/flex/index.html

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
DIANA M. BONTÁ, R.N., Dr.P.H.
Director

GRAY DAVIS
Governor

OFFICE OF AIDS **Care Services Program**	**Management Memorandum** **Memorandum Number: 02-09**

DATE:

TO: **TITLE II FISCAL AGENTS**

SUBJECT: **NEW DATA REPORTING REQUIREMENTS**

Topic: Health Resources Services Administration (HRSA) requires that the Care Services Program (CSP) annually report aggregate-level data provided by Title II funded agencies (CARE Act Data Report). This type of data collection does not allow the CSP to follow clients and services across providers, counties, or service areas.

Summary: Beginning April 1, 2003, providers will be required to collect and report client-level data. Client name and other identifying information should not be reported to the Office of AIDS (OA). Client-level data reporting overcomes the limitations of the CARE Act Data Report which collects aggregate level data. Client-level data helps the OA monitor health outcomes and service utilization patters, and ensures the accuracy and usefulness of Care Services Program data. The First Quarter Report (April 1, 2003 through June 30, 2003) is due to the OA on July 31, 2003.

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www.consumerenergycenter.org/flex/index.html

Summary: (continued)

You may choose from one of the following software options to submit your data:

- The Ryan White CAREWare (The CAREWare technical support contact number is 1-877-294-3571. The software is free.),
- The CMP/Care Services Database (free software), or
- Your current data collection system provided that it meets HRSA's export format specifications for submitting client-level data. (If you want to use your current in-house system, please contact Ms. Denise Absher at (916) 322-3150 for system requirements.)

Please contact Ms. Denise Absher if you would like to receive a copy of the CAREWare or if you would like to schedule CAREWare training. More information will be distributed as the new contract year approaches.

Action Required:

Please file this management memorandum in your Administrative Manual and forward a copy to your service providers.

Peg Taylor, Chief
CARE Section
Office of AIDS

cc: See Next Page

Consortia Liaisons:

Jeff Byers	Liz Voelkert	Leona Lucchetti	Cynthia Garey	Barbara Weiss
(916) 327-6804	(916) 327-6792	(916) 445-1180	(916) 324-1611	(916) 323-3740

cc: Ms. Stella Kile
CARE Section
Office of AIDS
Department of Health Services
611 North Seventh Street, Suite A
Sacramento, CA 95814-0208

Ms. Denise Absher
Care Research and Evaluation Section
Office of AIDS
Department of Health Services
611 North Seventh Street, Suite A
Sacramento, CA 95814-0208

Exhibit 1

CARE Act Legislation

CARE Act legislation is accessible through the worldwide web. To access this legislation, do the following:

1. Go to: http://thomas.loc.gov/
2. Under "Legislation," click on "**Public Laws by Law Number**."
3. Under "Select Congress," click on "**101**."
4. Click on "**101-351 - 101-400**."
5. Page down to number "381" and click on "**S.2240**."
6. Page down to "**Text of Legislation**" and click on it.
7. Click on "**Full Display**."

COUNTY	FISCAL AGENT
Alameda/Contra Costa	Gary Schriebman Alameda County Health Care Services Office of AIDS (510) 873-6512
Amador/Calaveras/Tuolumne	Shelly Hance Amador-Tuolumne Comm. Action Agency (559) 737-4660
Butte/Colusa/Glenn/Sutter/Yolo/Yuba	W. Jay Coughlin United Way of Butte & Glenn Counties (530) 342-7898
Fresno	Alan Gilmore Dept. of Community Health (559) 445-3324
Humboldt/Del Norte	Alexandra Wineland Humboldt County Dept. of Public Health (707) 268-2122
Imperial	Joe Picazo Imperial County Public Health (760) 339-4438
Inyo	Randi Lee Dept. of Health & Human Services of Inyo County (760) 878-0081
Kern	Donna Goins Kern County Health Dept. (661) 868-0205
Kings	Barbara Van Buren Kings County Health Dept. (559) 584-1401 x 4531
Lake	Anne McAfee Mendocino Community Health Clinic (707) 468-1010 x 122
Los Angeles County	Charles Henry County of Los Angeles – OAPP (213) 351-8001

COUNTY	FISCAL AGENT
Madera	Ann Harris Madera County Dept. of Public Health (559) 675-7627
Mendocino	Rosalie Anchordoguy Mendocino County Public Health (707) 463-4573
Merced/Mariposa	Karen Resner Merced County Dept. of Public Health (209) 381-1036
Mono	Mary Booher Mono County Health Dept. (760) 932-7485
Monterey	Wayne Johnson Monterey County AIDS Project (831) 772-8200
Napa	Dr. Robert Hill Napa County Health & Human Services (707) 253-4566
Nevada	Mary Ann Newnan Nevada County Community Health Dept. (530) 470-2420
Orange	Alice Moore Orange County Health Care Agency (714) 834-3121
Plumas/Sierra/Lassen/Modoc/ Siskiyou	Rita Scardaci County of Plumas (530) 283-6337
Sacramento/Alpine/El Dorado/ Placer	Adrienne Rogers Sacramento County Dept. of Health (916) 875-6211
San Benito	Robin Jay San Benito County Health & Human Services (831) 636-4180

COUNTY	FISCAL AGENT
San Bernardino/Riverside	Coleen Tracy San Bernardino County Dept. of Public Health (909) 387-6222
San Diego	Janice DiCroce San Diego County Health and Human Services Agency (619) 515-6679
San Francisco/Marin/San Mateo	Michelle Dixon Dept. of Public Health (415) 554-9043
San Joaquin	Geneva Bell-Sanford Public Health Services, San Joaquin County (209) 468-3891
San Luis Obispo	Nancy Rosen San Luis Obispo County Health Agency (805) 781-5518
Santa Barbara	Pam Stowe County of Santa Barbara (805) 681-5465
Santa Clara	Audrey Broner Santa Clara County Public Health Dept. (408) 885-7711
Santa Cruz	Betsy McCarty Santa Cruz County Health Services Agency (831) 454-4490
Shasta/Trinity/Tehama	Daniel Johnson Northern Valley Catholic Social Service (530) 247-3327
Solano	Peter Turner Solano County Health & Social Services Dept. (707) 553-5557
Sonoma	Patricia Kuta County of Sonoma Dept. of Health Services (707) 565-7379

COUNTY	FISCAL AGENT
Stanislaus	Patty Stone Doctors Medical Center Foundation (209) 527-3412
Tulare	Mary Beth Hash Tulare County Health & Humas Services Agency (559) 733-6123 x219
Ventura	Craig Webb Ventura Public Health (805) 677-5227

CONSORTIA LIAISON ASSIGNMENTS

Jeff Byers (916) 327-6804	**Cynthia Garey** (916) 324-1611	**Leona Lucchetti** (916) 445-1180	**Liz Voelkert** (916) 327-6792
Inland Empire (Riverside & San Bernardino)	Inyo	ACT 3 (Amador, Calaveras, Tuolumne)	Fresno
Los Angeles	Kern	Butte Group (Butte, Glenn, Yuba, Yolo, Sutter, Colusa)	Humboldt (includes Del Norte)
Oakland EMA (Alameda & Contra Costa)	Kings	Monterey	Imperial
Orange	Madera	Napa	Lake
Sacramento (Alpine, Placer, El Dorado, Sacramento)	Merced/Mariposa	Nevada	Mendocino
San Francisco (Marin, San Francisco, San Mateo)	Mono	Santa Cruz	Mt. Counties (Plumas, Lassen, Sierra, Modoc, Siskiyou)
Santa Clara	San Benito	Shasta/Trinity/ Tehama	San Diego
	San Joaquin	Solano	San Luis Obispo
	Stanislaus	Sonoma	Ventura
	Tulare		

CARE Act Approved Services

Health Care Services	Description
Ambulatory/Outpatient Medical Care	Provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient, community-based and/or office-based setting. This includes diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care. Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with Public Health Service guidelines. Such care must include access to antiretrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
Dental Care	Diagnostic, prophylactic and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners.
Drug Reimbursement Program	On-going service/program to pay for approved pharmaceuticals and or medications for persons with no other payment source. Subcategories include: a. **State AIDS Drug Assistance Program (ADAP):** Title II CARE Act-funded and administered program or other state-funded Drug Reimbursement Program, or b. **Local/Consortia Drug Reimbursement Program**: A program established, operated and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or to broaden eligibility beyond that established by a State-operated Title II or other State-funded Drug Reimbursement Program. *Medications* include prescription drugs provided through an ADAP to prolong life or prevent the deterioration of health. The definition does not include medications that are dispensed or administered during the course of a regular medical visit, that are considered part of the services provided during that visit. If medications are an item paid for and dispensed as part of a *Direct Emergency Financial Assistance Program*, they should be reported as such.

Health Care Services	Description
Health Insurance	A program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health insurance program, including risk pools.
Home Health Care	Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that includes appropriate health care professionals. Component services include: a. Durable medical equipment; b. Homemaker or home health aide services and personal care services; c. Day treatment or other partial hospitalization services; d. Intravenous and aerosolized drug therapy, including prescription drugs; e. Routine diagnostic testing administered in the home of the individual; and f. Appropriate mental health, developmental, and rehabilitation services. Home- and community-based care does not include inpatient hospital services or nursing home and other long term care facilities.
Hospice Services:	a. **Home-Based Hospice Care** : Nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting. b. **Residential Hospice Care** : Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.
In-Patient Personnel Costs:	Within the limitations of the legislation, up to ten percent of the total award is allowable for such costs, if it has been determined by the Planning Council, that a shortage of inpatient personnel exists which has resulted in inappropriate utilization of inpatient services.
Mental Health Therapy/ Counseling	Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental health professional licensed or authorized within the State, including psychiatrists, psychologists, clinical nurse specialists, social workers, and counselors.

Health Care Services	Description
Nutritional Counseling	Provision of nutrition education and/or counseling provided by a licensed/registered dietitian outside of a primary care visit. Nutritional Counseling provided by other than a licensed/registered dietitian should be provided under *Counseling (other)*. Provision of food, meals, or nutritional supplements should be reported as a part of the sub-category, *Food and/Home-Delivered Meals/Nutritional Supplements*, under support services.
Rehabilitation Care	Services provided by a licensed or authorized professional in accordance with an individualized plan of care which is intended to improve or maintain a client's quality of life and optimal capacity for self-care. This definition includes physical therapy, speech pathology, and low-vision training services.
Substance Abuse Treatment/Counseling	Provision of treatment and/or counseling and to address substance abuse issues (including alcohol, legal and illegal drugs), provided in an outpatient or residential health service setting.
HIV/AIDS Treatment Adherence	Provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.
SUPPORT SERVICES	**DESCRIPTION**
Adoption/Foster Care Assistance	Assistance in placing children younger than 20 in temporary (foster care) or permanent (adoption) homes because their parents have died or are unable to care for them due to HIV-related illness.
Buddy/Companion Services	Activities provided by volunteers or peers to assist a client in performing household or personal tasks. Buddies also provide mental and social support to combat loneliness and isolation.
Case Management	A range of client-centered services that link clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, on-going assessment of the client's and other family member's needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and revision of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of service.

Support Services	Description
Client Advocacy	Assessment of individual need, provision of advice and assistance obtaining medical, social, community, legal, financial and other needed services. Advocacy does not involve coordination and follow-up on medical treatments.
Counseling (Other)	Individual and/or group counseling services other than mental health counseling, provided to clients, family, and/or friends by non-licensed counselors. May include psychosocial providers, peer counseling/support group services, caregiver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling, or education.
Day or Respite Care	Home- or community-based non-medical assistance designed to relieve the primary care giver responsible for providing day-to-day care of client or client's child.
Direct Emergency Financial Assistance	Provision of short-term payments for transportation, food, essential utilities or medication assistance, which planning councils, Title II grantees, and consortia may allocate and which **must be carefully monitored to assure limited amounts, limited use, and for limited periods of time**. Expenditures must be reported under the relevant service category.
Food Bank/Home Delivered Meals/Nutritional Supplements	Provision of actual food, meals, or nutritional supplements.
Health Education/Risk Reduction	(1) Provision of information including information dissemination about medical and psychosocial support services and counseling or (2) preparation/distribution of materials in the context of medical and psychosocial support services to educate clients with HIV about methods to reduce the spread of HIV.
Housing Assistance	This is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of Title I, II and IV funds for short-term or emergency housing must be linked to medical and/or supportive services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.
Housing Related Services	Includes assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State, and Federal housing programs and how they can be accessed.

Support Services	Description
Legal Services	Legal services directly necessitated by a person's HIV status including: preparation of Powers of Attorney, Do Not Resuscitate Orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. See also, Permanency Planning and Adoption/Foster Care.
Outreach	Programs which have as their principal purpose identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services, not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached, and be designed with quantified program reporting which will accommodate local effectiveness evaluation. Broad marketing of the availability of health care services for PLWH should be prioritized and funded as Planning Council or Consortium support activities.
Permanency Planning	The provision of social service counseling or legal counsel regarding: a. the drafting of wills or delegating powers of attorney; and b. the preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.
Referral	The act of directing a person to a service in person or through telephone, written, or other type of communication. Referral may be made formally from one clinical provider to another, within a case management system by professional case managers, informally through support staff or as part of an outreach program.
Transportation	Conveyance services provided to a client in order to access health care or psychosocial support services. May be provided routinely or on an emergency basis.
Other State Priorities	Non-direct services or programs, or non-administrative activities which have been determined to be a priority by the State for effective implementation of the Title II-funded programs/services. Examples include activities such as, volunteer training and coordination, capacity-building activities to improve the capacity of community-based and/or minority providers to deliver services to clients with HIV infection, quality assurance, and continuous quality improvement.

Support Services	Description
Other Support Services	Direct support services not listed above, such as translation or interpretation services.
Program Support	Activities that are not service oriented or administrative in nature, but contribute to or help to improve service delivery. Such activities may include capacity building, technical assistance, program evaluation (including outcome assessment), quality assurance, and assessment of service delivery patterns.

Exhibit 5

Program Policy Notices 97-01, 97-02, 97-03

http://www.hab.hrsa.gov/i/dss_policies.htm

Financial Status Report

Reporting Period: _____ Contractor: _____ Contract Number: _____
Total Grant Award: _____

Service Provider (Subcontractor)	Total Contract	Expended To Date	Balance	Percentage Expended	# of Unduplicated Served	WIC Expenditures		
						Allocated	Expended	Balance
Needs Assessment								
Fiscal Agent Administrative Costs								
Total								

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MO 20857

Dear Colleagues:

There is no question that a lack of access to high quality health care and tremendous disparities in health outcomes for many Americans are a major problem for our Nation. In recognition of this, the Health Resources and Services Administration (HRSA) has adopted a goal of “100% access, 0% disparity” for all of our programs, including the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Simply stated, this means that we are redoubling our focus on achieving access to high quality health care for all persons living with HIV/AIDS and eliminating race, gender, and geographic disparities in health outcome.

We are writing to ask you to examine your own programmatic decisions and priorities in the light of this goal. Disparities in health outcome, lack of access to quality health care, pharmaceuticals, and other necessary services which allow people to access and remain in care continue to challenge all of us fighting for the lives of people living with HIV/AIDS. This is particularly important in light of the potential benefit that can be offered by high quality care and by appropriate use of new anti-retroviral regimens. The Ryan White CARE Act provides one of the only mechanisms whereby our “100% access, 0% disparity” goal can be achieved in the face of this epidemic.

HRSA believes it is essential, therefore, that services supported with CARE Act funds relate to this goal. In particular, social and support services should be designed to assist persons living with HIV/AIDS to overcome barriers to accessing and to sustain participation in health care services. We urge that services which do not meet this criteria not be prioritized for CARE Act funding.

We recognize that difficult decisions are made at all levels of the CARE Act program every day and we do not presume to know what exact package of services will best serve your particular community. Communities will ultimately decide for themselves how best to achieve “100% access and 0” disparities” for people living with HIV/AIDS. This request that you partner with us and examine your own efforts in light of HRSA’s goals is intended, rather, to provide direction for local processes, focus program management, and to articulate a national context for the Ryan White Program. We stand prepared to offer technical assistance and support as you address these issues and intend to devote a considerable portion of our upcoming All Title meeting to these issues.

We look forward to strengthening our partnership with you to better meet our goal of “100% access, 0% disparities” for our most vulnerable citizens.

Sincerely,

Claude Earl Fox, M.D., M.P.H.
Administrator

Exhibit 10

Sample AAR Forms and Instructions to Complete

To obtain sample AAR forms and instructions on how to complete these forms, please contact Denise Absher, at (916) 322-3150.

INVOICE DETAIL

Contractor: Name _____ Contract No. _____

Address_____

City_____ County _____

Fiscal Agent _____ Service Period: Mo._____ Yr. ___

Contact Person _____

Provided Services HRSA Categories	**Total Allocated**	**Expenditures To Date**	**Expenditures Current Month**	**Balance Remaining**
Home Health Care				$ -
Direct Emergency Financial Assist.				$ -
Food Bank / Home Delivered Meals				$ -
Housing Assistance (short Term)				$ -
Transportation				$ -
				$ -
Delivery Operations:				$ -
Administrative				$ -
Indirect/Operational/Equipment				$ -
				$ -
				$ -
FISCAL AGENT COSTS:				$ -
Administrative				$ -
Operating Expenses				$ -
Capitol Expenses				$ -
Indirect Costs				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
TOTAL	$ -	$ -	$ -	$ -

Exhibit D

TITLE II CONSORTIUM INVOICE

Contractor Name / Fiscal Agent

Consortium Name

Mailing Address

Contract Number

Month of Service

Budgeted Categories	Contracted Amount	Amount Invoiced To Date	Amount Invoiced This Month	Remaining Contract Amount
A. PERSONNEL				$ -
B. OPERATING EXPENSES				$ -
C, CAPITAL EXPENDITURES				$ -
D. OTHER COSTS				$ -
E. INDIRECT COSTS				$ -
TOTAL	$ -	$ -	$ -	$ -
LESS ADVANCE PAYMENT (if applicable)				$ -
TOTAL AMOUNT PAYABLE	$ -	$ -	$ -	$ -

I hereby certify that the amount claimd is accurate and a true representation of the amount owed.

Date Authorized Signature Title

Department of Health Services
Office of AIDS
P.O. Bos 942732
Sacramento, Ca. 94234-7320

INVOICE DETAIL

Contractor: Name _____ Contract No. _____

Address_____

City_____ County _____

Fiscal Agent _____ Service Period: Mo._____ Yr. ___

Contact Person _____

Provided Services HRSA Categories	Total Allocated	Expenditures To Date	Expenditures Current Month	Balance Remaining
Home Health Care				$ -
Direct Emergency Financial Assist.				$ -
Food Bank / Home Delivered Meals				$ -
Housing Assistance (short Term)				$ -
Transportation				$ -
				$ -
Delivery Operations:				$ -
Administrative				$ -
Indirect/Operational/Equipment				$ -
				$ -
				$ -
FISCAL AGENT COSTS:				$ -
Administrative				$ -
Operating Expenses				$ -
Capitol Expenses				$ -
Indirect Costs				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
TOTAL	$ -	$ -	$ -	$ -

Exhibit 11

Fact Sheet

http://www.hab.hrsa.gov/B/factsheets/title2-1.htm

The following table is an overview of the activities conducted during the year by the Office of AIDS, Fiscal Agent, and Consortia.

April **01:** Consortia begins needs assessment process • Reviews past year's needs assessment **20:** OA compiles final previous year's expenditure information for submittal to HRSA **20:** OA compiles final current year's subcontractor budget allocation data for submittal to HRSA	**May** **01:** Consortia continues needs assessment process • Determines who will conduct • Determines how it will be conducted • Revises tools as needed	**June** **01:** Consortia conducts needs assessment **15:** OA gathering current year's contractor certifications and budget exhibits for submittal to HRSA **30:** Deadline for submittal of year-end report (report period 10/ 1 – 3/ 31) **30:** Deadline for submittal of final invoice
July **01:** Consortia develops criteria for resource allocation	**August** **01:** Consortia tabulates needs assessment data	**September** **01 Through November 30:** Consortia: • Prioritizes data received from needs assessment • Determines allocation to service categories • Establishes a service delivery plan • Provides information to fiscal agent

October	November	December
TBA: Distribution by HRSA of next year's Title II Application to State	**17:** Deadline for submittal to OA of current year's expenditure information and request for funding augmentation through reallocation process **15:** Deadline for submittal of mid-year report (report period 4/ 1 – 9/ 30) **30:** OA's distribution of Title II Consortia Program Application to current fiscal agents **November (continued)** **30**: Consortia provides prioritized list of service categories and service delivery plan to fiscal agent	**01 through January 20:** Fiscal agent prepares and conducts selection of service providers (RFP process) **04:** Announcement of augmentation awards **TBA:** Deadline for OA's submittal of State Title II Program Application to HRSA
January	**February**	**March**
02: Fiscal agent and consortia begin writing Annual Ryan White Application to State Office of AIDS **20:** Fiscal agent completes selection of service providers	**TBA:** Submit completed annual Ryan White Application to OA **15:** Deadline for submittal to OA of AAR Calendar Year Report – reporting period 1/ 1 – 12/ 31	**05:** Fiscal Agents to receive written responses from OA regarding status of Title II Consortia Application **20**: Consortia evaluates: • Their success in responding to service needs • How the consortia functions **31:** Deadline for submittal of Consortia Program information and documents in response to OA letter **31:** Deadline for incurring expenses under Year 10 contracts

Exhibit 13

Contract Between OA and Fiscal Agent

Please refer to your individual contract that you have with the Office of AIDS.