HIV/AIDS Bureau, Division of Service Systems Monitoring Standards for Ryan White Part A and B Grantees: Part I: Universal Standards

(Covers Both Fiscal and Program Requirements)

Note: These Monitoring Standards are designed to provide clear guidance to Ryan White Part A and Part B grantees about HRSA/HAB expects in terms of monitoring both your own work and provider performance. The Standards provide benchmarks that both meet federal legislative and regulatory guidelines and represent sound practice. You use Universal and Service category-specific Standards of Care to guide provider contracting and program monitoring. These Universal Monitoring Standards complement Universal Standards of Care by helping you as a grantee to ensure that providers meet legislative and regulatory intent as they implement and manage their programs. As a grantee, you have full responsibility for the delivery and management of Ryan White services and funds within your service area – you are responsible for the performance of grantee staff and your providers. The Standards assume that a provider of services can be a sub-grantee, subcontractor, consortium, or the lead agency that administers the program (often the health department). If you are both the grantee and a direct provider of services, you must meet both the grantee and the provider responsibilities described here. Except when they refer to *contractors* – meaning any entity with which you have a legal agreement – these Standards are *not* designed for use with subcontractors that provide professional or technical support (such as needs assessment or quality management). They are designed specifically for direct service providers. HRSA/HAB hopes and expects that you will use the Standards both to inform your own monitoring and to provide guidance to providers.

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Section A: Access to Care				RW Part A 2605 (a)(7)(A-C) RW Part B 2617 (b)(7)(B)(i-iii) RW Part B ADAP 2616(c)(4-5) 2602(b)(2)(G) 2617(b)(7)(A)
Structured and ongoing efforts to obtain input from clients in the design and delivery of services	 Documentation of Consumer Advisory Board and public meetings minutes Documentation of 	Review documentation at the subgrantee level to determiner methods used for	Maintain file of materials documenting Consumer Advisory Board (CAB) membership and	RW Part A 2605 (a)(7)(B) RW Part B 2617 (b)(7)(B)(ii) ADAP 2616(c)(4)

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	existence and appropriateness of a suggestion box or other client input mechanism • Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted at least annually	obtaining consumer input into the delivery of services Use results of same or similar methods in the design and refinement of the HIV continuum of care	meetings, including minutes Regularly implement client satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented Maintain visible suggestion box or other client input mechanism	2602(b)(2)(G) 2617 (b)(7)(A)
2. Provision of services regardless of an individual's ability to pay for the service	Agency billing and collection policies and procedures that do not: Deny services for non-payment Deny payment for inability to produce income documentation Require full payment prior to service Include any other procedure that denies services for non-payment	 Review agency's billing, collection, copay, and sliding fee policies and procedures to ensure that they do not result in denial of services Investigate any complaints against the agency for denial of services Review file of refused clients and client complaints 	 Have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services regardless of the client's ability to pay Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients, with documentation of complaint review and decision reached 	RW Part A 2605 (a)(7)(A)(i) RW Part B 2617(b) (7)(B)(i) ADAP 2616(c)(4-5)
3. Provision of services regardless of the current or past health condition of the individual to be served	Documentation of eligibility and clinical policies to ensure that they do not:	 Review agency eligibility and clinical policies Investigate any 	 Maintain files of eligibility and clinical policies Maintain file of 	RW Part A 2605 (a)(7)(A)(ii)

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	 Permit denial of services due to pre-existing conditions Permit denial of services due to non-HIV-related conditions (primary care) Provide any other barrier to care due to a person's past or present health condition 	complaints of agency "dumping" or "cherry picking" patients	individuals refused services [as described above]	
4. Provision of services in a setting accessible to low-income individuals with HIV disease	 A facility that is handicapped accessible, accessible by public transportation Policies and procedures that provide transportation if facility is not accessible to public transportation No policies that dictate a dress code or conduct that may act as a barrier to care for low-income individuals 	 Inspect service provider facility for ADA compliance, location of facility with regard to access to public transportation Review policies and procedures for providing transportation assistance if facility is not accessible by public transportation 	 Comply with Americans with Disabilities Act (ADA) requirements Ensure that the facility is accessible by public transportation or provide for transportation assistance 	RW Part A 2605(a) (7)(B) RW Part B 2617 (b) (7)(B)(ii) ADAP 2616(c)(4)
5. Efforts to inform low- income individuals of the availability of HIV-related services and how to access them	Informational materials about agency services and eligibility requirements including: • Brochures • Newsletters • Posters • Community Bulletins • Any other types of promotional materials	Review documents indicating activities for promotion and awareness of the availability of HIV services	Maintain file documenting agency activities for the promotion of HIV services to low- income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements	RW Part A 2605 (a)(7)(C) RW Part B 2617 (b)(7)(B)(iii) ADAP 2616(c)(5)

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Section B: Eligibility Determination/ Screening 1. Screening and	Documentation of	Establish an EMA,	Develop and maintain	RW Part B 2616(B) Part A and B Guidances
reassessment of clients to determine eligibility as specified by the EMA, TGA, or state: • Screening of clients to determine eligibility for Ryan White services within a predetermined timeframe • Reassessment of clients every 6 months to determine continued eligibility	eligibility required in client records, with copies of documents (e.g., proof of HIV status, proof of residence, proof of income eligibility, proof of insurance, uninsured or underinsured), using approved documentation as required by the EMA, TGA or the State Eligibility and Determination and Enrollment forms for other third party payors such as Medicaid and Medicare Eligibility policy and procedures on file Documentation that all staff involved in eligibility determination has participated in required training. Agency client data report that meets funder requirements	 TGA or Statewide process and policies for determining eligibility Conduct site visits to review client files for appropriate documentation that meets the requirements Provide training to new and existing agencies and new staff on eligibility, assessment and reassessment of clients Provide training to subgrantees on third party payment sources Monitor the receipt and use of third party payments by providers as an indication of the use 	client files that contain documentation of client's eligibility, including the following: HIV/AIDS diagnosis Low income (Note: for ADAP supplemental, low income is defined as not more than 200% of the Federal Poverty Level) Uninsured or underinsured status (Insurance verification as proof) Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare For underinsured, ineligibility for service	

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	 Documentation of reassessment of client's eligibility status every six months Training provided by the Grantee/contractor to ensure understanding of the policy and procedures Agency client data report consistent with funding requirements 	of third party payors by subgrantees Review data reports for accuracy Use monthly, and quarterly progress reports to identify and address problems in the process of determining eligibility Work with fiscal department to ensure eligible clients are receiving allowable services that are fundable with Ryan White dollars Develop and Monitor reports that include client utilization and expenditure reports by agency, by service category and by EMA, TGA or State	 Proof of compliance with eligibility as defined by the EMA, TGA or State Document that the process for establishing eligibility, assessment, and reassessment takes place within time frames established by the EMA, TGA or State Document that all staff involved in eligibility determination have participated in required training Ensure agency client data report consistent with funding requirements, which demonstrates that eligible clients are receiving allowable services [See Program Monitoring section for a list of allowable services.] 	
2. Eligibility policies that do not deem a veteran living with	Documented evidence that the agency's eligibility	Ensure those providers that are funded to	Ensure that policies and procedures classify	Policy 04-01 and Parham letter 8/04
HIV ineligible for Ryan White	policies (written or verbal) do	assess eligibility are	veterans receiving VA	
services due to eligibility for Department of Veterans	not consider VA health benefits as the veteran's	aware of and are consistently	health benefits as uninsured, thus	
Affairs (VA) health care	primary insurance and deny	implementing the	exempting these veterans	
benefits	access to Ryan White	veteran classification	from the "payor of last	

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	services citing "payor of last resort"	policy	resort" requirement	
Section C: Anti-Kickback Statute				42 USC1320a 42 USC13207b(b) Part A and B Notice of Grant Award Standard Terms Part A and B Assurances
1. Demonstrated structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally funded program .	 Employee Code of Ethics including: Conflict of Interest Prohibition on use of agency property, information or position without approval or to advance personal interest Fair dealing – engaged in fair and open competition Confidentiality Protection and use of company assets Compliance with laws, rules, and regulations Timely and truthful disclosure of significant accounting deficiencies Timely and truthful disclosure of noncompliance For Medicare/Medicaid providers, a Corporate Compliance Plan 	 Require by contract that subgrantees have: Employee Code of Ethics For Medicare and Medicaid providers, a Corporate Compliance Plan Bylaws and policies that include ethics standards or business conduct practices During site visits, verify compliance with contract antikickback conditions 	 Maintain and review file documentation of: Corporate Compliance Plan (required by HCFA if providing Medicare- or Medicaid-reimbursable services) Personnel Policies Code of Ethics or Standards of Conduct Bylaws and Board policies File documentations of any employee or Board Member violation of the Code of Ethics or Standards of Conduct Documentation of any complaint of violation of the 	42 USC 1320a- 7b(b)

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	 (required by HCFA) that provides for: Compliance officer Compliance committee Formal training programs Effective lines of communication to report suspected noncompliance Auditing (breaks in internal controls) Corrective action plans Instance and format to report non-compliance to Medicare and Medicaid anti-kickback regulation Nonprofit agency Bylaws or Board policies that include standards of conduct for members, including: Conflict of interest No use of agency assets for personal use Procedures for open door communication 		Code of Ethics or Standards of Conduct and its resolution • For not-for-profit contractors/grantee organizations, ensure documentation of agency Bylaws, Board Code of Ethics, and business conduct practices	
2. Prohibition of employees (as individuals or entities) from soliciting or receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other	 Contracts that discourage agency payments for service referral Provider recruitment practices that prohibit exorbitant signing bonuses 	Do on-site assessment including review of file documentation on: Contracts Key employee background checks Recruitment	Maintain documentation of: Service contracts Key employee background checks Recruitment practices Audit management	42 U.S.C. 1320 7b(b)

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federally funded program 3. Prohibition of employees (as individuals or entities),	 Audit findings on internal controls Procurement policies with conflict of interest clauses Prohibition of higher charges for Medicare/Medicaid services 	practices	letters Compliance audits or compliance checks Have adequate policies	42 U.S.C. 13207b(b)
from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.	Key employee background checks Any other documentation required by the Compliance Plan or employee conduct standards	on-site assessment that cover: Contracts, MOU, agreements Recruitment policies and procedures that discourage signing bonuses Conflict of interest Prohibition of exorbitant signing packages Policies that discourage the use of two charge masters, one for self pay clients and a higher one for insurance companies. Proof of employee background checks Purchasing policies that discourage kickbacks and referral bonuses	and procedures to discourage soliciting cash or in-kind payments for: Awarding contracts Referring clients Purchasing goods or services and/or Submitting fraudulent billings Have employee policies that discourage: The hiring of persons with a criminal record The hiring of persons being investigated by Medicare or Medicaid Large signing bonuses	

Standard	Performance Measure/	Grantee	Provider/Subgrantee	Source
	Method	Responsibility	Responsibility	Citation
4. Requirement that entities providing Medicaid/Medicare billable services have a Compliance Plan/employee standard of conduct that distinguishes and describes conduct that merits agency penalties from conduct that represents a possible felony	Compliance Plan and/or employee standard of conduct and/or not for profit agency bylaws that detail types of conduct that merit agency penalties versus types of conduct that are possible felonies that require: Timely and truthful disclosure of non compliance to federal agency If convicted, a fine of not more than \$25,000 or imprisoned for not more than five years, or both	Maintain file documentation of assessment of the: Conduct type agency penalty Penalties and disclosure procedures for conduct deemed to be felonies Proof of inclusion and application of safe harbor laws	Have in place policies and procedures that: Delineate penalties and disclosure procedures for conduct deemed to be felonies Include and describe the safe harbors laws Include the reporting of non-compliance with the policy	42 U.S.C. 1320 7b(b)
5. Requirement that any Compliance Plan and/or employee standard of conduct describe conduct that merits exemption from anti-kickback regulations (safe-harbors)	Information is found in the compliance plan/employee standards of conduct that describes practices that are exempt from prosecution; included are: • Some investments in ambulatory surgical centers • Agencies in under-served areas that: • Enter into Joint Ventures • Have practitioner recruitment plans • Sell physician practices to hospitals • Give subsidies for	Maintain file documentation of the uses and applications of the safe harbor laws that exempt certain practices from anti- kickback implications	Include in the anti- kickback policy the implications, appropriate uses, and application of safe harbors	42 U.S.C. 1320 7b(b)

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
	obstetrical malpractice insurance Have specialty referral arrangements between providers Cooperative agreements with 501(e) hospitals			
Section D: Grantee Accountability				2 CFR 215.17(b)3 OMB 102 45 CFR 92.3 Part A 2010 Guidance Section II.3(b) Title II Manual 2003 Section II Chapter 4
Proper stewardship of all grant funds including compliance with programmatic requirements	Policies, procedures, and contracts that require: Timely submission of detailed fiscal reports by funding source, with expenses allocated by service category Timely submission of programmatic reports Documentation of method used to track unobligated balances and carryover funds A documented reallocation process Report of total number of funded providers A-133 or single audit Auditor management letter	Include as contract requirements: Clear and concise contract language that outlines programmatic and fiscal requirements A programmatic and fiscal monitoring system which includes monthly and or quarterly timeframes for ensuring compliance Reports that provide financial information by: Funding source (formula, supplemental,	 Meet contracted programmatic and fiscal requirements Closely monitor any contractors Develop reports that allow the tracking of Ryan White funds by Formula, Supplemental, MAI, ADAP and ADAP Supplemental, by service category and by provider Commission independent audits; for those meeting thresholds, audits that meet A-133 requirements 	2 CFR 215.17(b)3

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		MAI, ADAP and ADAP Supplemental) By allowable uses core, support, administration By service categories (outpatient medical care, etc.) Review A-133 audits when submitted by providers	Develop financial and agency Policies and Procedures Manual that meet federal and Ryan White program requirements	
2. Accountability by the grantee for the expenditure of funds it shares with lead agencies (usually health departments), providers, and/or consortia	 A copy of each contract Fiscal, program site visit reports and action plans Audit reports Documented reports that track funds by formula, supplemental, service categories Documented reports that track unobligated balance and carryover funds Documented reallocation process Report of total number of funded providers Grantee A-133 or single audit conducted annually and made available to the state every two years 	 Ensure timely submission to HRSA of fiscal and programmatic reports Include clear and concise contract language that outlines programmatic and fiscal requirements Develop a programmatic and fiscal monitoring system that includes monthly and or quarterly timeframes for ensuring compliance 	 Establish and implement:: Fiscal and general policies and procedures that include compliance with federal and Ryan white programmatic requirements. Flexible fiscal reporting systems that allow the tracking of unobligated balances and carryover funds and detail service reporting of funding sources Timely submission of independent audits (A-133 audits if required) to grantee 	

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	Auditor management letter	 Review A-133 and other audits submitted by providers Submission of provider audit reports to the State every two years 		
3. Business management systems that meet the requirements of the Office of Management and Budget code of federal regulations, programmatic expectations outlined in the grantee assurances and the Notice of Grant Award	 Review of subgrantee contracts Fiscal and program site visit reports and action plans Policies and Procedures that outline compliance with federal and Ryan White programmatic requirements Independent audits Auditor management letter 	 Comply with and require subgrantee compliance with the requirements in the following documents. Ryan White Part A and B assurances 45 CFR 75 or 45 CFR 94 or 48 CFR Part 31 2 CFR 215 or 230 or 220 OMB 102 HHS Grant Policy Statement (Terms and Conditions) Notice of Award (NOA) Program conditions, terms and reporting requirements 	Ensure that the following are in place: documented policies and procedures and fiscal/programmatic reports that provide effective control over and accountability for all funds in accordance with federal and Ryan White programmatic requirements	2 CFR 215.17(b)3 OMB 102 45 CFR 92.3
4. Responsibility for activities	Desk audits of budgets,	 Develop monitoring 	Ensure policies and	2CFR215.17 (b)3

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that are supported under the Ryan White Program as outlined by Office of Management and Budget, Code of Federal Regulations, HHS Grant Policy Statement (Terms and Conditions), Program Assurances, and Notice of Grant Award (NGA)	applications, yearly expenses, programmatic reports; audit reports or onsite review when assessing compliance with fiscal and programmatic requirements:	systems to enforce and ensure compliance • Ensure that systems require the maintenance of documentation that supports proof of compliance • Include contract language that requires compliance with OMB, CFR, program assurances, Notice of Grant Award terms, and standards	procedures and flexible fiscal and programmatic systems that can meet compliance with federal and Ryan white programmatic requirements	OMB 102 45CFR 92.3
Section E: Reporting				45 CFR 74.50-51 45 CFR 92.40-41 Part A Manual 2009 Section VI (2) Part A Manual 2009 Section III (2-4) (A-C)
Submission of standard reports as required in circulars as well as programspecific reports as outlined in the Notice of Grant Award Required reports and due dates: Report Due Date	Records that contain and adequately identify the source of information pertaining to: • Federal award revenue, expenses, obligations, unobligated balances, assets, outlays, program income, interest	Assess financial and program performance of recipients (grantees, subgrantees/ providers), who are required to submit the grantor standard report	 Ensure: Submission of timely provider reports File documentation or data containing analysis of required reports to determine accuracy and any reconciliation with 	Part A Manual 2009 Section VI (2) Part A Manual 2009 Section III (2-4) (A-C) Title II (Part B) Manual Section III Chapters 1-4

Standa	ard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Revised Budget narrative	90 days after budget start period	 Client level data Aggregate data on services provided; clients served, client demographics, and 	Comply with HRSA/HAB/DSS annual instruction and formats for the Part A program	existing financial or programmatic data. Example: Test program income final FFR with calendar	
Planned allocations	90 days budget start period	selected financial information	reporting requirements Obtain from subgrantees the	year RDR. • Submission of periodic financial reports that document the	
Implementation Plan	90 days budget start period		information (data or reports) needed to meet Ryan White Part A reporting	expenditure of Ryan White funds, positive and negative spending variances, and how	
List Providers and CRC	150 days budget start period		requirements	funds have been reallocated to other line-items or service categories	
Final FFR and Carryover Request	90 days after end of budget period				
ICY Report	120 days after end of budget period				
Final Annual Progress Report	150 days after end of budget period				
Final Expenditures	150 days after end of budget period				
Interim FSR	150 days after start				

Standa	ard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
Part B midyear progress report Calendar year RDR Quarterly ADAP Due the last day following the end quarters, which a June, July-Septe October-Decemb January-March, sis the start date	of the month of the re April- mber, er, and				
Section I: Monitoring 1. Any agency or receiving federal required to monit compliance with the requirements and programmatic ex	funding or for ederal I	Development and consistent implementation of policies and procedures that establish uniform administrative requirements governing the monitoring of awards	 Develop policies and procedures that establish uniform administrative requirements Document in subgrant agreements or service contracts the frequency, reports and expectations of monitoring activities 	 Participate in and provide all material necessary to carry out monitoring activities. Monitor any service contractors for compliance with federal and programmatic requirements 	45CFR 74

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expected to include annual site visits of all Provider/Sub grantee.	Review of the following program monitoring documents and actions: Policies and procedures Tools, protocols, or methodologies Reports Corrective site action plans Progress on meeting goals of corrective action plans	 Use a combination of several of the following to monitor program compliance: program reports, annual site visits, client satisfaction reviews, capacity development/ technical assistance, and chart or records reviews Keep to a reasonable level the time and resources contractors must spend to meet their reporting obligations Review the following program monitoring documents: Policies and procedures Tool, protocol, or methodology Reports Corrective site action plan Progress on meeting goals of corrective action plan 	Establish policies and procedures to ensure compliance with federal and programmatic requirements Submit auditable reports Provide the grantee access to financial documentation	Part A Manual II 3 A Inspector General 2004 OEI-02-01- 00641 Best practices DSS expectations
monitoring activities to ensure	Review of the following fiscal monitoring documents and actions:	Have documented evidence of:Fiscal monitoring	Have documented evidence that federal funds have been used for	Part A Manual II. Introduction 3 A- A-D

Standard	Performance Measure/ Method	Grantee Responsibility	Provider/Subgrantee Responsibility	Source Citation
being used for approved purposes	 Fiscal monitoring policy and procedures Fiscal monitoring tool or protocol Fiscal monitoring reports Fiscal monitoring corrective action plans Compliance with goals of corrective action plans 	activities Records reviews Supporting documentation of paid expenditures An annual financial audit by a qualified independent accountant Have on file a copy of all subgrantee procurement documents including subgrant agreements/ contracts, letters of agreements, MOUs, and fiscal and programmatic site visit reports	allowable services and spent in accordance with Federal requirements and Ryan White expectations	
 4. Corrective actions taken when provider outcomes do not meet program objectives and grantee expectations, which may include: Improved oversight Redistribution of funds A "corrective action" letter Sponsored technical assistance 	 Review of corrective action plans Review of resolution of issues identified in corrective action plan Policies that describe actions to be taken when issues are not resolved in a timely manner 	Establish and implement monitoring policies that require a compliance report that lists in order of gravity the identified non-compliance activities, requires a corrective action plan, and establishes a time limit for response	 Prepare and submit: Timely and detailed response to monitoring findings Timely progress reports on implementation of corrective action plan 	Part A Manual, II. Introduction 3 A A-D

Grantee Provider/Subgra	
and implementation of measures that will bring subgrantee into compliance • Provide the awarding agency with monitoring reports, corrective action plans, and progress reports on the resolution of any findings of a	iy Ontarion
	Responsibility and implementation of measures that will bring subgrantee into compliance • Provide the awarding agency with monitoring reports, corrective action plans, and progress reports on the resolution of any