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Acronyms

ADAP: AIDS Drug Assistance Program
AIDS: Acquired Immunodeficiency Syndrome
CAP: corrective action plan
DHHS: Utah Department of Health and Human Services
FPL: federal poverty level
HAB: HIV/AIDS Bureau

HHS: United States Department of Health and Human Services

HIPAA: Health Insurance Portability and Accountability Act

HIV: Human Immunodeficiency Virus

HRSA: Health Resources and Services Administration

QA: quality assurance

QI: quality improvement

ROI: release of information

RWB: Ryan White Part B Program

SRL: Salary Rate Limitation

TA: technical assistance

Definitions of terms

Client record: location where protected client information and documentation is located, this includes ClientTrack and others as identified.

ClientTrack: the data system containing Utah RWB client records, which is administered by the DHHS and is accessible to authorized users.

FPL: the poverty guidelines are updated periodically in the federal register by HHS under the authority of 42 U.S.C. 9902(2).

Program: means the Utah Ryan White Part B Program.

QA: a broad spectrum of activities aimed at ensuring compliance with minimum quality standards. Activities include the retrospective process of measuring compliance with standards (e.g., service standards). Site visits and chart reviews are examples of commonly used QA activities. QA is not the same as QI, although the results of QA activities can be used to develop QI activities.

QI: the development and implementation of activities to make changes to the program in response to performance measure results. QI activities are aimed at improving client care, health outcomes, and/or satisfaction.

Recipient: is usually, but not limited to, a non-federal entity that receives a federal award directly from a federal awarding agency to carry out an activity under a federal program.

Subrecipient: is a non-federal entity that receives a sub-award from a pass-through entity to carry out part of a federal program and is accountable to the recipient for the use of the funds provided; but does not include an individual that is a beneficiary of such program. A subrecipient may also be a recipient of other federal awards directly from a federal awarding agency.

Universal service standards

Universal service standards apply to all service categories funded under RWB. If a standard differs by service category, then the difference is described within the specific service category standard. Standards are compliant with the HRSA/HAB National Monitoring Standards (June 2022). Recipients are required by HRSA/HAB to adhere to these standards and subrecipients funded for RWB services are held to the same standards. Additional expectations may apply.

Access to care

Standard

A. Services provided in a setting accessible to individuals with HIV who are low-income and comply with the Americans with Disabilities Act (ADA) Barrier-Free Health Care Initiative.
B. Services provided irrespective of age, physical or mental challenges, creed, criminal history, history of substance use, immigration status, marital status, national origin, race, sexual orientation, gender identity and expression, socioeconomic status, or current/past health conditions.
C. Delivery operational hours are posted online or at the facility with voicemail greetings to include hours of operation, and how to contact after business hours.
D. Establish formal collaborative agreements with HIV and other service organizations.
E. Service informs clients of HIV services and resources available throughout the state.
F. Process for identification of referral and follow-up with identified HIV and other service providers.
G. Structured and ongoing efforts to obtain input from people with HIV in the design and delivery of services.

Measures

A. ADA policy and procedure
B. Non-discrimination policy and procedure
C. Posted and voicemail greeting with operational hours and after-hours contact
D. Memoranda of Agreement/Understanding
E. Documentation of resource(s) given in client record (Informational flyers, handouts, resource manuals, literature, etc.)
F. Referral and follow-up policy and procedure
G. Documentation of appropriate mechanism(s) for obtaining client input (e.g., satisfaction survey tools, focus groups, and/or public meetings, etc.)

Records management

Standard

Client record

Includes all relevant information about the client related to service delivery, facilitates communication, and ensures service coordination. ClientTrack is the approved repository for all client record documentation.

Client record:

A. Is unique for each enrolled client.
B. Is complete, accurate, confidential, and secure.
C. Avoids
   - Casual abbreviations.
   - Not reading out loud before saving.
   - Generalization or over-interpretations.
   - Grammatical errors.
   - Negative, biased, and prejudiced language.
   - Details of the client's intimate life unless it is relevant to the treatment/service plan.
   - Inadequate content for billing documentation (e.g., one sentence for three hours of service delivery is unacceptable).
   - Use of unconfirmed medical diagnoses unverified by a medical provider (e.g., instead of "the client is depressed," document "client stated having feelings of sadness or depressed mood" or "client describes seeing hallucinations or feeling sad on a daily basis").
   - Duplication of information for the same client or multiple clients seen by the same provider.
   - Information regarding other clients receiving service.
D. Is only accessed by authorized personnel who:
   - Use a secure, encrypted, and password-protected system to share, transfer, email, and fax items containing personally identifiable information including client records, confidential information, legal documents, invoices, and correspondence. Request a ClientTrack user account for each staff member authorized to handle client records.
   - Request a ClientTrack user account for each staff member authorized to handle client records.
   - Have their user account; no shared accounts are allowed.
   - Safeguard ClientTrack usernames and passwords against use by anyone other than the registered user.

- Inform the Program within 3 business days when a ClientTrack user terminates employment or is no longer authorized to handle client records in ClientTrack.

Billing

Sufficient documentation is required to substantiate the units billed for service delivery. Billing units are entered into ClientTrack within 3 business days of service rendered. Compliance is determined by assessing documentation content to validate that the services are related to client care and correlate with service date and units billed. Only billing units required by contract and entered into ClientTrack are reimbursed by the Program. Payment may be denied if documentation is insufficient to substantiate units billed.
Documentation may include but is not limited to:

- Service date/category.
- Service provided.
- Duration of encounter.
- Method of client interaction (e.g., face-to-face, email, phone conversation).
- Objective, factual, accurate, necessary, clear, concise, and specific communication.

Measures

Documentation in ClientTrack complies with standards for client records and billing.

Staff requirements/personnel qualifications

Standard

A. Job descriptions address minimum qualifications, core competencies, and job responsibilities.
B. Staff receive ongoing supervision, which is relevant to their professional needs.
C. Staff delivering direct services to clients receive training on the following:
    - HIV/AIDS-related
        - Illnesses and common comorbidities.
        - Psychosocial effects on clients and their families/significant others.
        - Resources and services in Utah.
        - Strategies for management.
        - Ryan White Part B Program requirements.
    - Compassionate, non-judgmental, and comprehensive services.
    - Cultural and linguistic competency
    - Code of conduct for their professional discipline.

- Employee self-care activities to deliberately care for staff's mental, emotional, and physical health.

D. Policies and procedures:
   - Linguistic services:
     - Provided as a component of HIV service delivery between the provider and the client to facilitate communication between the client and provider and the delivery of RWB-eligible services in both group and individual settings.
     - Services provided by appropriately trained and qualified individuals holding appropriate state or local certifications.
     - Services provided comply with the National Standards for CLAS.
   - Code of conduct.
   - Home visit.
   - Safety and emergency include:
     - Services provided in facilities that are clean, comfortable, and free from hazards.
     - Physical safety plan.
     - Emergency procedures for fire, severe weather, intruder/weapon threats, and medical/healthcare crises.
     - Infection control and transmission risk crisis management.
     - Risk assessment accident/incident reporting.

Measures

Documentation of:

A. Job descriptions.
B. Supervisory review policy and procedure
C. Organizational chart
D. Staff training completion: list of staff members, role, training topic, frequency and completion date, certificate of completion, transcripts/logs, continuing education units, staff interview, in-service attendance, etc.
E. Policies and procedures.

Eligibility determination/screening

Standard

A. Eligibility policies and procedures include:
   - Timeframe expectations for new clients:
     - Contact the client within two (2) business days of request or referral for services.
     - Proof of HIV status within ten (10) business days after intake
   - Client screening to determine referral needs and eligibility for appropriate RWB services.
   - HIV positive status.
   - FPL.
   - State residency.
   - Not deeming a veteran living with HIV and eligible for Department of Veterans Affairs (VA) health care benefits ineligible for RWB services.
   - Not deeming American Indians and Alaska Natives ineligible for services.
   - RWB funds are used as the payor of last resort.
   - Vigorous pursuit of other payors and/or accessing funds from other resources where available.
   - RWB eligibility verification at the time of service.
B. Benefits Specialists connect with clients to assist with application/re-certification.

Measures

Documentation of:

A. Policies and procedures.
B. Client contact and intake timeframe expectations in the client record.
C. Benefits counseling/enrollment in the client record.

Client-related policies

Standard

Subrecipient:

A. Reviews annually.
B. Communicates policies to the client, gives a copy of the client-signed policy to the client, and uploads a copy to the client record.
C. Policies containing information, processes, and documentation expectations include:
   - Rights and responsibilities.
   - Privacy and confidentiality.
   - Grievance.
   - Retention in medical care.

- Re-engagement to care.
- Transition, which includes: transfer, case closure, and administrative discharge.

Rights and responsibilities

- Available services and options
- The ability to voluntarily withdraw from the program or terminate service at any time.
- Transfer and transition procedures
- Client progress review
- Access to client records
- Scheduling, rescheduling, and canceling appointments
- Additional client rights may include:
  - Treated with respect, dignity, consideration, and compassion.
  - Services free of discrimination.
  - Participation in creating a care plan.
  - Agreement about the frequency of contact, either face-to-face or over the phone.
  - A grievance process about services received or denied.
  - Not subjected to physical, sexual, verbal, and/or emotional abuse or threats.
  - Record confidentiality.
  - Information released only when:
    - A written ROI is signed by the client.
    - Ordered by a court of law.
    - A medical emergency exists such as a medical or behavioral condition, with sudden onset manifested by symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in 1) an immediate danger to the client or others, 2) possible child or elder abuse, 3) serious impairment to the person's bodily function, dysfunction of any bodily organ or part, disfigurement, or jeopardy of the health of the person afflicted with the condition.

Client responsibilities include:

- Treat other clients and staff with respect and courtesy.
- Protect the confidentiality of other clients.
- Participate in creating a care plan.
- Inform the agency of any concerns or changes in needs.
- Make and keep appointments, or contact agency to cancel or change an appointment time.

- Inform the agency of the change in address and phone number.
- Respond to communications related to services promptly.
- No drug or alcohol use on-premises.
- No weapons on premises.
- No acts of abuse towards staff, property, or services.
- No physical, sexual, verbal, and/or emotional abuse or threats to agency staff.

Privacy and confidentiality

A. Client record and other personal information are:
    - Securely faxed, emailed, phoned, or transmitted electronically using a secure system.
    - Safely transported during the course of conducting business.
    - Securely stored electronically or physically with limited access.
    - Shared with third parties in accordance with HIPAA Privacy and Security Rules.
    - Maintained in a secure location and protected from unauthorized use.
    - Password protected with access limited to appropriate personnel.
B. Documentation and forms follow established policies and protocols including HIPAA Privacy and Security Rules and the Utah Public Health Code.
C. The client receives information regarding information privacy and security.
D. Notice of privacy practices prior to receiving services.
E. Client signed notice of privacy practices for the provision of services is time–limited not to exceed 12 months.
F. Coordination of care prior to third-party disclosures if applicable.
G. ROI, if indicated, includes at a minimum:
    - Time limit not to exceed 12 months.
    - To whom the information will be released, including the name of the organization, person or emergency contact, address, etc.
    - What specific information will be released.
    - Printed name and signature of client/legal guardian.
    - Process to ensure a client or client's legal guardian understands signing a release to obtain and disclose information will allow sharing information from the client's record, with whom, and for what purpose.

Grievance

A. The client receives information regarding the Grievance policy.
B. The client may file a grievance if there is a complaint or concern about services received or denied.
C. The service provider documents the grievance, status, and resolution.

D. The grievance policy contains at a minimum the process for resolving client grievances, including:
   - Identification of whom to contact.
   - Applicable timelines.
   - Tracking grievances.

Retention in medical care

Regular assessment and follow-up are established to encourage and retain a client in medical treatment. A pattern of broken appointments can lead to discontinuity of medical care services and a lack of compliance with treatment adherence. Subrecipient has a policy for:

A. Retention in care.
B. Broken appointment.

Re-engagement to care

The subrecipient determines if a staff case review is needed to establish a re-engagement plan. This is required if a previous transition was due to inappropriate behavior affecting self or others such as, but not limited to client abuse of agency staff, property and services, illegal substance use on the agency premises, activities violating the confidentiality of other clients at the agency, fraudulence and/or fabrication of documents.

Transition

Change in level or location of service.

A. Prior to transition, if possible, the provider meets with a client, face-to-face concerning reasons for transition and options for ongoing services. If not possible, the provider meets with the client virtually or talks with the client via phone.
B. If contact is not possible, a certified letter is sent to the client's last known address. If the client is not present to sign for the letter, it is returned to the provider.
C. Policy is established for types of client transition including transfer, case closure, and administrative discharge.

Transfer

A. Client criteria:
   - Transfer to another agency
   - Needs are more appropriately addressed in other programs/services
   - Moves out of state or relocates outside of the geographic service area

B. If the client moves to another area, the transferring agency arranges a referral for needed services in the new location.
C. The transferring agency provides a transfer summary, and other requested records, within thirty (30) business days of request.
D. Transfer documentation in client record includes:
    - Date services began.
    - Date of transfer.
    - Reason(s) for transfer.
    - Client special needs.
    - Services needed/actions taken (if applicable).
    - Referrals made at the time of transfer (if applicable).
    - Transfer plan and summary within thirty (30) business days of the transfer.

Case closure

A. Client criteria:
    - Completion of services
    - Services are no longer needed
    - Ineligible for services
    - Eligibility verification cannot be obtained
    - Verification of HIV-positive status cannot be obtained within ten (10) business days of intake.
    - Client/legal guardian has requested the case be closed
    - Withdraws from or refuses funded services
    - Not participating in the care plan
    - Fails to maintain contact with the Benefits Specialist staff for a period of three (3) months despite three (3) documented attempts to contact.
    - Exhibits pattern of abuse, towards staff, property, or services as defined by the agency's policy.
    - Housed in an institutional program, anticipated to last for a minimum of thirty (30) days, such as a nursing home, prison, or inpatient program.
    - Deceased
B. Unable to locate:
    - The agency will attempt to locate and document contact attempts (by phone or face-to-face) a minimum of three (3) times, on three (3) separate dates, over a three (3) month period after the first attempt.
    - Within five (5) business days after the last attempt to notify the client, a certified letter is mailed to the client's last known mailing address. The letter states the case will be closed within thirty (30) days from the date on the letter if an appointment with the provider is not made.

C. Withdrawal from service: If the client reports services are no longer needed or chooses not to participate in the care plan, the client may withdraw from services. An exit interview with the client is scheduled to determine:
   - Reason(s) for withdrawal.
   - Factors interfering with the client's ability to fully participate.
   - If services are still needed.
   - Referral needs for issues that cannot be managed by the agency.

D. Case closure documentation in client record includes:
   - Date services began.
   - Date of closure.
   - Contact or attempted contact method:
     - Phone calls
     - Written correspondence
     - Direct contact
     - Other technological means, such as virtual meetings or text messaging
   - Summary with a clear rationale for closure within thirty (30) business days of service ending. Include the following if applicable:
     - Certified letter
     - Referrals made at the time of case closure
     - Services needed/actions taken

Administrative discharge

A. Client criteria: behavior that abuses the safety, or violates the confidentiality of others.
B. Case review by leadership prior to administrative discharge.
C. A certified letter including the reason for discharge and alternative resources is mailed to the client's last known mailing address within five (5) business days after the date of discharge.
D. Referrals made at the time of discharge (if applicable).
E. Administrative discharge documentation in client record includes:
   - Date services began.
   - Date of discharge.
   - Discharge summary with a clear rationale for discharge within thirty (30) business days of service ending.
   - Certified letter.

Measures

A. Policies present, contain required content, and show documentation of annual review.
B. Client-signed and dated forms are located in the client record (as applicable).

Fiscal

Standard

See additional fiscal standards in the monitoring section

Procedures

A. Subrecipient provides:
   - Program and fiscal staff resume and job descriptions.
   - Staffing plan.
   - Organizational chart.
   - Budget and justification.

B. Establish policies and procedures:
   - For handling RWB revenue including program income.
   - That allows the recipient as funding agency prompt and full access to financial, program, and management records and documents as needed for the program and fiscal monitoring and oversight.

C. Establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources.

D. Make available to the recipient upon request:
   - Policies and process
   - Payroll records and allocation methodology

E. Maintain:
   - detailed chart of accounts and general ledger to provide tracking of RWB revenue.
   - Payroll records for specified employees.
   - File documentation of payroll records and accounts payable, and hard-copy expenditures data.
   - Data documenting reimbursement period, including monthly bank reconciliation reports and receivables aging report.
   - Document reconciliation of advances to actual expenses.
   - Submit invoices on time monthly, with complete documentation.

Limitation of uses

A. Prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses.

B. Prepare a project budget that meets administrative cost guidelines.

C. Provide administrative expense report with sufficient detail to permit review and track administrative cost elements.

D. If using indirect cost as part of 10% administration costs, obtain and keep on file an HHS-negotiated, federally approved Certificate of Cost Allocation Plan or Certificate of Indirect Costs; submit a current copy of the certificate to the recipient.
E. Report to the recipient expenses by service category.
F. Documentation to support service funds are contributing to positive medical outcomes for clients.
G. True up; fee justification.

Unallowable costs

A. Maintain a file with signed subrecipient agreements, assurances, and/or certifications that specify unallowable costs.
B. Maintain documentation of policies that prohibit the use of RWB funds for cash payments to service recipients.
C. Maintain a file documenting all travel expenses paid by RWB funds.
D. Ensure budgets do not include unallowable costs.
E. Ensure expenditures do not include unallowable costs.
F. Provide budgets and financial expenses reports to the recipient with sufficient detail to document they do not include unallowable costs.
G. Provide a detailed program plan of outreach activities that demonstrates how the outreach goes beyond HIV prevention education to include testing and early entry into care.
H. Prepare a detailed program plan and budget narrative to describe the planned use of any advertising or marketing activities.
I. Include in the personnel manual and employee orientation information on regulations that forbid lobbying with federal funds.

Service fee income

A. Staff training on policy for RWB payer of last resort, and how the requirement is met.
B. Each client screened for insurance coverage and eligibility for third-party programs and helped to apply for such coverage, with documentation of this in client records.
C. Carry out internal reviews of files and billing system to ensure that RWB resources are used only when a third-party payer is not available.
D. Establish and maintain medical practice management systems for billing.
E. Establish and consistently implement in medical offices and pharmacies billing and collection:
    - Policies and procedures.

- Process and/or electronic system.

F. Documentation of accounts receivable.
G. Document and maintain file information on the recipient or individual provider agency Medicaid status.
H. Maintain a file of contracts with Medicaid insurance companies. If no Medicaid certification, document current efforts to obtain such certification. If certification is not feasible, request a waiver where appropriate.
I. Bill, track, and report to the recipient all program income billed and obtained.

Imposition and assessment of client charges

A. Establish, document, and have available for review:
   - Policy for a current schedule of charges.
   - Client eligibility determination in client records.
   - Fees charged by the provider and payments made to that provider by the client.
   - Process for obtaining and documenting client charges and payments through an accounting system manual or electronic.
B. Establish and maintain a schedule of charges policy that includes:
   - A cap on charges.
   - Personnel are aware of and consistently follow the policy and schedule of charges and cap on charges.
   - A process for alerting the billing system that the client has reached the cap and should not be further charged for the remainder of the year.
   - Responsibility for the client eligibility determination to establish individual fees and caps.
C. Tracking of first RWB charges or medical expenses inclusive of enrollment fees, deductible, co-payments, etc.
D. Document:
   - Policy for the schedule of charges does not allow clients below 100% of FPL to be charged for services.
   - Personnel are aware of and consistently follow the policy and schedule of charges.
   - Policy for the schedule of charges must be publicly posted.

Financial management

A. Ensure adequacy of agency fiscal systems to generate needed budgets and expenditure reports, including:
   - Accounting policies and procedures.
   - Budgets.

- Accounting system and reports.

B. Submit a line-item budget with sufficient detail to permit review and assessment of the proposed use of funds for the management and delivery of the proposed services.
C. Document all requests for and approvals of budget revisions.
D. Document and report on compliance as specified by the recipient.
E. Establish policies and procedures to ensure compliance with subrecipient provisions.

Property standards-equipment

A. Develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source.
B. Develop and maintain a current, complete, and accurate supply and medication inventory list.
C. Establish and maintain policies and procedures that acknowledge the revisionary interest of the federal government over property improved or purchased with federal dollars.

Cost principles

A. Ensure budgets and expenses conform to federal cost principles.
B. Ensure fiscal staff familiarity with applicable federal regulations.
C. Make available to the recipient:
   - Detailed information on the allocation and costing out of expenses for services provided.
   - Policies, procedures, and calculations.
   - Detailed expense reports to enable them to document that costs are at or below the cost of providing the drugs through ADAP.
D. Calculate unit costs based on historical data.
E. Reconcile projected unit costs with actual unit costs on a yearly or quarterly basis.
F. Reasonable methodologies for allocating costs among different funding sources and RWB categories.
G. Systems that can provide expenses and client utilization data in sufficient detail to calculate and determine the reasonableness of unit costs.
H. Unit cost calculations are available for recipient review.
I. Participate in the 340 B Pricing Program.
J. Policies and procedures:
   - Ensure contract requirements are met.
   - Meet federal requirements.

- Determine allowable and reasonable costs.

Matching or cost-sharing funds

The subrecipient, on behalf of the recipient, provides matching or cost-sharing funds following the same verification process as the recipient.

Unobligated balances

A. Report to the recipient:
   - Monthly expenditures to date.
   - Any unspent funds.

B. Inform the recipient of variances in expenditures.
C. Provide timely reporting of unspent funds, position vacancies, etc. to the recipient.
D. Establish and implement a process for tracking unspent RWB funds and provide accurate and timely reporting to the recipient.
F. Carry out monthly monitoring of expenses to detect and implement cost-saving strategies.

Auditing requirements

A. Conduct a timely annual audit (an agency audit or an A-133 audit, depending on the amount of federal funds).
B. Request a management letter from the auditor.
C. Submit the audit and management letter to the recipient.
D. Prepare and provide the auditor with:
   - Income and expense reports that include payer of last resort verification.
   - Financial and other documents required to conduct a major program audit (e.g. income and expense reports that include payer of last resort verification, timesheets, general ledger, etc.).
E. Provide audit to the recipient on a timely basis.
F. Provide the recipient with the agency's response to any reportable conditions.
G. Comply with contract audit requirements on a timely basis.
H. Comply with audit requirements A-133.
I. Policies and procedures available to the recipient on request.

Measures

Documentation of

A. List and schedule available to the recipient upon request.
B. Policies and procedures.

Quality management

Standard

Subrecipient participates in quality management, including:

- Identification of a person responsible for quality management.
- Quality training for team leads.
- Performance measures.
- QA.
- QI activities aimed at improving client care, health outcomes, and client satisfaction.
- Client satisfaction evaluation.

Performance measures

According to HRSA Policy Clarification Notice #15-02, required performance measure monitoring and reporting is based on service category utilization.

Percent of RWB-eligible clients receiving at least one unit of service for an RWB-funded service category	Minimum # of performance measures
≥ 50%	2
> 15% to < 50%	1
≤ 15%	0

- HRSA strongly encourages the use of HRSA/HAB performance measures. For details including rationale, inclusion, and exclusion criteria, refer to: HRSA Ryan White HIV/AIDS Program Performance Measure Portfolio.
- The subrecipient enters the required performance measure(s) data on 100% of RWB clients and results are reviewed quarterly, at the RWB Clinical Quality Management (CQM) meeting.

QA monitoring

- Is conducted to assure the quality of care delivered.
- Encourages the use of HRSA/HAB performance measures.
- Results may be used to identify and inform QI projects.

QI activities

- Follow a structured methodology such as Plan-Do-Study-Act.
- Are reported quarterly at the CQM meeting.
- Are related to client care, satisfaction, or health outcomes.

Client satisfaction

Evaluation

- Is conducted annually at a minimum.
- Assess client satisfaction and quality of services.
- Used to improve client satisfaction, quality of care, or health outcomes.
- Methods may include:
  - Satisfaction survey.
  - Feedback request.
  - Suggestion box or other client input mechanism.
  - Focus groups and/or public meetings.

Measures

Documentation of:

- Person responsible for quality.
- Quality training for team leads.
- Performance measure data entered and reviewed quarterly.
- QA monitoring and results used to inform QI if indicated.
- QI methodology with a focus on improvement in client care, satisfaction, or health outcomes.
- QI activities reported quarterly.
- Client satisfaction evaluation.

Monitoring

Standard

A. Any agency or individual receiving federal funding is monitored to ensure compliance with federal requirements, and programmatic expectations. The subrecipient participates in and provides all material necessary to carry out monitoring activities.
B. Annual subrecipient site visit includes:
   - Policies and procedures to ensure compliance with federal and programmatic requirements.
   - Audit reports
   - Financial documentation, client charts, and other documents needed for monitoring.
C. Fiscal monitoring activities to ensure RWB funds are used only for approved services. Documented evidence that federal funds have been used for allowable services and comply with federal regulations and RWB requirements.
D. Salary Rate Limitation (SRL): HRSA funds may not be used to pay the salary of an individual at a rate in excess of an Executive Level II employee. This amount

reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. The SRL also applies to sub-awards for substantive work under a HRSA grant or cooperative agreement.

Subrecipient monitors:

- Staff salaries to determine the SRL.
- Prorated salaries to ensure the salary, when calculated at one hundred percent does not exceed the SRL.

E. SRL fringe benefits. If an individual is under the salary cap limitation, fringe is applied as usual. If an individual is over the salary cap limitation, fringe is calculated on the adjusted base salary.

F. Corrective actions are taken when subrecipient outcomes do not meet program objectives and expectations which may include:

- Improved oversight.
- Redistribution of funds.
- A corrective action letter.
- TA.

Measures

Documentation of:

- Timely and detailed responses to monitoring findings.
  - Progress reports on the implementation of corrective action plans.
  - Policies and procedures to ensure compliance with federal and programmatic requirements.
  - Audit reports.

Resources

[HIPAA Privacy Rule]
[HIPAA Security Rule]
[HRSA Clinical Quality Management Policy Clarification Notice #15-02]
[HRSA Eligible Individuals & Allowable Use of Funds Policy Clarification Notice #16-02]
[HRSA National Monitoring Standards for Ryan White HIV/AIDS Program Part B Recipients]
[HRSA Performance Measure Portfolio]
[HRSA Ryan White HIV/AIDS Program - Part B Manual]
[Utah Ryan White Part B Program Clinical Quality Management Plan]
[Utah Ryan White Part B Program Manual]

Revised	Reviewer	Change description or location
2023.06.22	ClientTrack administrator	Clarified we comply with the HIPAA Privacy and Security Rules, but we're not covered by the other parts. Added links under Resources. Replaced *consent* with *notice of privacy practices*.
2023.06.14	Financial manager & Fiscal analyst	Reviewed 2022 HRSA NMS, there are no policy changes that impact the template we use for our monitoring
2023.04.26	Quality consultant & Quality coordinator	Formatting, clarity and conciseness, comparison to 2022 HRSA NMS
2022.03.23	ADAP admin	Updated to DHHS guidelines

Approval group	Reviewed
ADAP administrator: Allison Allred	2023.03.23
Part B administrator: Seyha Ros	2023.05.01
ClientTrack administrator: Summer Bammes	2023.06.22
Quality coordinator: Marcee Mortensen	2023.04.26
Senior RN quality consultant: Vinnie Watkins	2023.04.26
Fiscal analyst III: Anna Packer	2023.06.28
Financial manager I: Derrick Blomquist	2023.06.28
HEART program manager: Tyler Fisher	2023.07.11
Office of Communicable Diseases director: Sam LeFevre	2023.07.11