TITLE: Universal Service Standards PROGRAM: Ryan White Part B SECTION: Administration, Fiscal, Quality Management & Service Delivery	
Executive Sponsor: Utah Department of Health and Human Services Policy Owner: Part B & ADAP Administrators Approved by: RWB and HIV/STD Prevention Manager	Last Review: 2022.04.01 Next Review: 2023.04.01 Origination Date: 2019.08.06

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Acronyms

ADAP AIDS Drug Assistance Program
AIDS acquired immunodeficiency syndrome
CAP corrective action plan
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
TA technical assistance
UDOH Utah Department of Health

Definitions of Terms

Client Record All entity and transaction data associated with a particular client in ClientTrack.
ClientTrack The data system containing Utah Ryan White Part B client records, which is administered by the Utah Department of Health and is accessible to authorized users here: https://www.clienttrack.net/UT_RW .
FPL The most current version of the poverty guidelines 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 Entails 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/Grantee 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/Contractor 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 are applicable to all service categories funded under RWB. If a Universal Standard differs by service category, then the difference is described within the specific service category standard. These Standards are compliant with the HRSA/HAB National Monitoring Standards (April 2013). Recipients/Grantees are required by HRSA/HAB to adhere to these standards and Subrecipients/Contractors funded for RWB services are held to the same standards.

Access to Care

1. Services are 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.
2. Services are provided in accordance with the Americans with Disabilities Act (ADA) Guidelines. For information, refer to ADA Guidelines.
3. Subrecipient/Contractor:
   A. Post hours and set voicemail greetings to include hours of operation, and how to contact after business hours.

B. Establish formal collaborative agreements with HIV and other service organizations.
C. Inform clients of HIV services and resources available throughout the state.
D. Have a resource referral and tracking system with identified HIV and other service providers.

Measures:

- Non-Discrimination/ADA Policy and Procedure.
- Posted hours/call greeting with hours.
- Memoranda of Agreement.
- Memoranda of Understanding.
- Documentation of resource(s) given in client record.
- Informational flyers, handouts, resource manuals, literature, etc.
- Referral tracking system.

Records Management

Subrecipient/Contractor responsibilities:

1. Collect one unique intake record for each enrolled client.
2. Ensure records are complete, accurate, confidential, and securely stored.
3. 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.
4. Ensure client records are handled only by authorized personnel.
5. Request a ClientTrack user account for each staff member authorized to handle client records. Each user must have their own user account; no shared accounts are allowed.
6. Safeguard ClientTrack usernames and passwords against use by anyone other than the registered user.
7. Promptly inform the Program when a ClientTrack user terminates employment or is no longer authorized to handle client records in ClientTrack.

Documentation

Documentation 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. Remember, if it is not documented, it never happened.

Content may include but is not limited to:

- Service date/category
- Service provided
- Method of client interaction (e.g., face-to-face, email, phone conversation)
- Sufficient information so anyone reading it can understand
- Objective, factual, accurate, necessary, clear, concise, and specific communication

Avoid:

- Casual abbreviations
- Not reading out loud before saving
- Generalization or over-interpretations
- Grammatical errors
- Negative, biased, and prejudice language
- Details of client's intimate life unless it is relevant to client treatment/service plan
- Inadequate content for billing documentation (e.g., one sentence for three hours of service delivery 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 for multiple clients seen by the same provider
- Information regarding other clients receiving service

Billing

Billing requires sufficient documentation to substantiate the units billed for service delivery. Payment may be denied if documentation is insufficient to substantiate units billed. Auditors determine compliance by assessing documentation content to validate the services are related to client care and correlate with service date and units billed. If required by contract, only those billing units entered into ClientTrack will be reimbursed by the Program.

Measures:

- Documentation of policy supporting records management components.
- Documentation in ClientTrack that meets Documentation and Billing Standards.
- Billing units entered into ClientTrack within 3 business days of service rendered.

Staff Requirements/Personnel Qualifications

Subrecipient/Contractor:

1. Staff job descriptions address minimum qualifications, core competencies, and job responsibilities.
2. Professional staff follow established codes of conduct for their discipline.
3. Receive ongoing supervision, which is relevant to their professional needs.
4. Staff delivering direct services to clients receive training on the following:
    A. Effects of HIV/AIDS-related illnesses and common comorbidities.
    B. Psychosocial effects of HIV/AIDS on clients and their families/significant others.
    C. Strategies for the management of HIV/AIDS.
    D. HIV-related resources and services in Utah.
5. Provide culturally and linguistically competent, compassionate, non-judgmental, and comprehensible services.

6. Safety and Emergency Procedures:
    A. Services are provided in facilities that are clean, comfortable, and free from hazards.
    B. Physical Safety Plan.
    C. Emergency Procedures that include fire, severe weather, and intruder/weapon threat Medical/Health Care Crisis.
    D. Infection Control and Transmission Risk Crisis Management.
    E. Risk Assessment Accident/Incident Reporting.
    F. Home Visit Protocol.
7. Employee self-care activities to deliberately take care of staff mental, emotional and physical health.

Measures:

Documentation of:

- Policies and procedures
    - Safety and Emergency Plans, Procedures and Protocols.
    - Code of Conduct.
    - Linguistic: ensuring languages and formats appropriate to the population served are available and staff training requirements.
- Job descriptions.
- Supervisory reviews.
- Employee self-care activities.
- Training (list of staff members, role, required training topic, frequency and completion date)
    - Code of Conduct.
    - Required of staff delivering direct services.
    - Annual cultural and linguistic competency.

- Safety and Emergency Procedures.
- Types of training documentation may include, but is not limited to, certificate of completion, transcripts/logs, continuing education units, staff interview, in-service attendance, etc.

Eligibility Determination/Screening

Subrecipient/Contractor:

1. Contact client within two (2) business days of request or referral for services.
2. Complete an initial intake within ten (10) business days of client contact.
3. Connect client with Benefits Specialist to assist with application/re-certification.
4. Establish:
   a. Proof of HIV status within ten (10) business days after intake.
   b. FPL.
   c. State residency.
5. Screen client to determine referral needs and eligibility for appropriate RWB service category(ies).
6. Ensure eligibility policy does not deem a veteran living with HIV eligible for Department of Veterans Affairs (VA) health care benefits ineligible for RWB services.
7. Ensure RWB funds are used as the payer of last resort.
8. Verify RWB eligibility at time of service.

Measures:

- Documentation in client record of:
  - Contact within two (2) business days of request or referral for services.
  - Intake completed within ten (10) business days of client contact.
  - Benefits counseling/enrollment.

- HIV positive status within ten (10) business days after intake.
- FPL.
- State residency.
- Screening to determine referral needs and eligibility for appropriate RWB service category(ies).
- Vigorous pursuit of other payors and/or accessing funds from other resources where available.
- RWB eligibility.

- Policies and procedures:
  - Client contact and intake timeframe expectations.
  - Benefits Specialists application/re-certification assistance.
  - HIV positive status, FPL and state residency.
  - Screening for referral needs and eligibility for appropriate RWB service category(ies).
  - Not deeming a veteran living with HIV eligible for Department of Veterans Affairs (VA) health care benefits ineligible for RWB services.
  - RWB funds are used as the payor of last resort.
  - RWB eligibility verification at time of service.

Client-Related Policy

The Subrecipient/Contractor:

1. Has written policies describing process and documentation pertaining to client-related information.
2. Policies are reviewed annually.

3. Communicate policy to client and provide a copy of client-signed and dated forms . A copy is documented in the client record.

Measure:

- Policies present and show documentation of annual review.
- Client signed and dated forms are located in the client record.

Rights and Responsibilities

1. Client Rights and Responsibilities include at a minimum:
   A. Available services and options.
   B. The ability to voluntarily withdraw from the program or terminate service at any time.
   C. Transfer and transition procedures.
   D. Client progress review.
   E. Access to client records.
   F. Scheduling, rescheduling, and canceling appointments.
2. Additional Client Rights and Responsibilities may include:
   A. Treated with respect, dignity, consideration, and compassion.
   B. Services free of discrimination.
   C. Participation in creating service plan.
   D. Agreement about frequency of contact, either in person or over the phone.
   E. A grievance process about services received or denied.
   F. Not subjected to physical, sexual, verbal, and/or emotional abuse or threats.
   G. Record confidentiality.
   H. Information released only when:
      i. A written ROI is signed by the client.

ii. A medical emergency exists such as medical or behavioral condition, with sudden onset, and manifests 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:
    - placing the health of the afflicted person with such a condition in se rious jeopardy.
    - serious impairment to the person's bodily functions.
    - serious dysfunction of any bodily organ or part; or
    - serious disfigurement.

iii. An immediate danger to the client or others is present.

iv. Possible child or elder abuse.

v. Ordered by a court of law.

3. Client Responsibilities
    A. Treat other clients and staff with respect and courtesy.
    B. Protect confidentiality of other clients.
    C. Participate in creating a service plan.
    D. Inform agency of any concerns or change in needs.
    E. Make and keep appointments, or contact agency to cancel or change an appointment time.
    F. Inform the agency of change in address and phone number.
    G. Respond to communications related to services in a timely manner.
    H. No drug or alcohol use on premises.
    I. No weapons on premises.
    J. No acts of abuse towards staff, property or services.

K. No physical, sexual, verbal, and/or emotional abuse or threats to agency staff.

Measure:

- Client Rights and Responsibilities form contains minimum requirements.
- Client Rights and Responsibilities form is signed and dated by client, and located in the client record.

Privacy and Confidentiality

Policy and procedures at a minimum ensure client record and other personal information is:

1. Securely faxed, emailed or phoned.
2. Safely transported during the course of conducting business.
3. Securely stored electronically or physically with limited access.
4. Shared with third parties in accordance with HIPAA.
5. Maintained in a secure location and protected from unauthorized use.
6. Electronic files are password protected with access limited to appropriate personnel.
7. Documentation and forms follow established policy and protocols including: HIPAA and the Utah Public Health Code.
8. The client receives information regarding HIPAA.
9. Client signed Consent for provision of services. Time–limit not to exceed 12 months.
10. ROI, if indicated, includes at a minimum:
    A. To whom information will be released, including name of organization or person (emergency contact), address, etc.
    B. What specific information will be released.

C. Time-limit not to exceed 12 months.

D. Printed name and signature of client/legal guardian

E. 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.

Measures:

- Privacy and Confidentiality policy and procedures include minimal requirements.
- Documentation in client record of signed and dated:
  - Consent prior to receiving services, including HIPAA.
  - ROI for coordination of care prior to third party disclosures (if applicable).

Grievance

Clients may file a grievance if there is complaint or concern about services received or denied.

1. The Grievance policy contains at a minimum the process for resolving client grievances, including identification of whom to contact, applicable timelines, and tracking grievances.
2. The client receives information regarding Grievance Policy.
3. The service provider documents grievance, status, and resolution.

Measure:

- Grievance policy contains minimum requirements.
- Documentation in client record of signed and dated:
  - Grievance Policy.
  - Grievance (if applicable).

Client Retention

Service providers strive to retain clients in medical care. A pattern of broken appointments can lead to discontinuity of medical care services, and lack of compliance with treatment adherence. Regular assessment and follow up is established to encourage and retain a client in medical treatment. The Subrecipient/Contractor has the following:

1. A Retention in Care Policy.
2. A Broken Appointment Policy.

Measure:

Documentation of:

- Retention in Care Policy.
- Broken Appointment Policy.

Re-Engagement Care

Policy for re-engagement to care for eligible clients. The provider determines if 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 confidentiality of other clients at the agency, fraudulence and/or fabrication of documents.

Measure:

Documentation of:

- Re-Engagement Policy.
- Staff case review (if applicable).

Transition

Transitions may include a change in level or location of service.

1. Transition Policy is established for client transfer, case closure and administrative discharge.

2. Prior to transition, if possible the provider meets with client concerning reasons for transition and options for ongoing services. When possible, meet face-to-face; if not possible, the provider meets with client virtually or talks with client via phone.
3. If contact is not possible, a certified letter is sent to client's last known address. If client is not present to sign for the letter, it must be returned to the provider.

Types of Transition:

1. Transfer
   A. Client Criteria:
      i. Transfers to another agency.
      ii. Needs are more appropriately addressed in other programs/services.
      iii. Moves out of state or relocates outside of the Subrecipient/Contractor's geographic service area.
   B. The transferring agency provides transfer summary, and other requested records, within (30) business days of request.
   C. If client moves to another area, the transferring agency arranges referral for needed services in the new location.
   D. Transfer documentation in client record includes:
      i. Date services began.
      ii. Date of transfer.
      iii. Reason(s) for transfer.
      iv. Client special needs.
      v. Services needed/actions taken (if applicable).
      vi. Referrals made at the time of transfer (if applicable).
      vii. Transfer plan and summary within thirty (30) business days of transfer.

2. Case Closure

A. Client Criteria:

i. Client/legal guardian has requested the case be closed.

ii. Inability to contact the client for more than six (6) months.

iii. Completion of services.

iv. Client death.

v. No longer meets eligibility requirements.

vi. Verification of HIV positive status cannot be obtained within ten (10) business days of intake.

vii. Eligibility verification cannot be obtained.

viii. Withdraws from or refuses funded services.

ix. Services are no longer needed.

x. No longer participates in the service plan.

xi. Fails to maintain contact with the Benefits Specialist staff for a period of three (3) months despite three (3) documented attempts to contact.

xii. Cannot be located.

xiii. Exhibits pattern of abuse, towards staff, property or services as defined by the agency's policy.

xiv. Becomes housed in an "institutional" program, anticipated to last for a minimum of thirty (30) days, such as a nursing home, prison, or inpatient program.

xv. Unable to Locate:

a. If client cannot be located, the agency will attempt to locate and document contact attempts (by phone or in person) a minimum of

three (3) times, on three (3) separate dates, over a three-month period after first attempt.

b. 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.

xvi. Withdrawal from Service: If the client reports services are no longer needed, or chooses not to participate in the service plan, the client may withdraw from services. An exit interview with the client is scheduled to determine:

a. Reason(s) for withdrawal.
b. Factors interfering with the client's ability to fully participate.
c. If services are still needed.
d. Referral needs for issues that cannot be managed by the agency.

B. Case Closure documentation in client record includes:

i. Date services began.
ii. Date of closure.
iii. Contact or attempted contact method:

a. Phone calls.
b. Written correspondence.
c. Direct contact.
d. Other technological means (such as virtual meeting or text messaging).

iv. Documentation summary with clear rationale for closure within thirty (30) business days of service ending. Include the following if applicable:
   a. Certified letter.
   b. Referrals made at the time of case closure.
   c. Services needed/actions taken.

3. 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 according to agency policy.

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. Administrative discharge documentation in client record includes:
   i. Date services began.
   ii. Date of discharge.
   v. Discharge summary with clear rationale for discharge within thirty (30) business days of service ending.
   vi. Certified letter.
   vii. Referrals made at the time of discharge (if applicable).

Measures:

Documentation of:

- Transition Policy for client transfer, case closure and discharge.
- Transition Policy compliance evident in client record where applicable.

Fiscal Standards

Fiscal Procedures

1. Prepare the following:
   A. Program and fiscal staff resume and job descriptions.
   B. Staffing Plan and Subrecipient/Contractor budget and budget justification.
   C. Subrecipient/Contractor organizational chart.
2. Establish policies and procedures:
   A. For handling RWB revenue including program income.
   B. That allow the Recipient/Grantee as funding agency prompt and full access to financial, program, and management records and documents as needed for program and fiscal monitoring and oversight.
3. Make the policies and process available for Recipient/Grantee review upon request.
4. Maintain detailed chart of accounts and general ledger to provide tracking of RWB revenue.
5. Document reconciliation of advances to actual expenses.
6. Maintain payroll records for specified employees.
7. Maintain file documentation of payroll records and accounts payable, and hard-copy expenditures data.
8. Make payroll records and allocation methodology available to Recipient/Grantee upon request.
9. Submit invoices on time monthly, with complete documentation.
10. Provide timely, properly documented invoices.
11. Maintain data documenting reimbursement period, including monthly bank

reconciliation reports and receivables aging report.

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

Limitation of Uses

1. Prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses.
2. Prepare project budget that meets administrative cost guidelines.
3. Provide administrative expense report with sufficient detail to permit review and track administrative cost elements.
4. 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/Grantee.
5. Report to the Recipient/Grantee expenses by service category.
6. Documentation to support service funds are contributing to positive medical outcomes for clients.
7. True Up; Fee Justification.

Unallowable Costs

1. Maintain a file with signed Subrecipient/Contractor agreement, assurances, and/or certifications that specify unallowable costs.
2. Ensure budgets do not include unallowable costs.
3. Ensure expenditures do not include unallowable costs.

4. Provide budgets and financial expenses reports to the Recipient/Grantee with sufficient detail to document they do not include unallowable costs.
5. Maintain documentation of policies that prohibit the use of RWB funds for cash payments to service recipients.
6. Prepare a detailed program plan and budget narrative to describe planned use of any advertising or marketing activities.
7. 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.
8. Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds.
9. Maintain a file documenting all travel expenses paid by RWB funds.

Service Fee Income

1. Staff training on Policy for RWB payer of last resort, and how the requirement is met.
2. 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.
3. 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.
4. Establish and maintain medical practice management systems for billing.
5. Establish and consistently implement in medical offices and pharmacies billing and collection:
    A. Policies and procedures.
    B. Process and/or electronic system.

6. Documentation of accounts receivable.
7. Document and maintain file information on Recipient/Grantee or individual provider agency Medicaid status.
8. Maintain 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.
9. Bill, track and report to the grantee all program income billed and obtained.

Imposition and Assessment of Client Charges

1. Establish, document, and have available for review:
   A. Policy for a current schedule of charges.
   B. Client eligibility determination in client records.
   C. Fees charged by the provider and payments made to that provider by client.
   D. Process for obtaining and documenting client charges and payments through an accounting system manual or electronic.
2. Document:
   A. Policy for schedule of charges does not allow clients below 100% of FPL to be charged for services.
   B. Personnel are aware of and consistently follow the policy and schedule of charges.
   C. Policy for schedule of charges must be publicly posted.
3. Establish and maintain a schedule of charges policy that includes a cap on charges and the following:
   A. Responsibility for client eligibility determination to establish individual fees and caps.

B. Tracking of first RWB charges or medical expenses inclusive of enrollment fees, deductible, co-payments, etc.
C. 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.
D. Personnel are aware of and consistently follow the policy and schedule of charges and cap on charges.

Financial Management

1. Ensure adequacy of agency fiscal systems to generate needed budgets and expenditure reports, including:
   A. Accounting policies and procedures.
   B. Budgets.
   C. Accounting system and reports.
2. Submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services.
3. Document all requests for and approvals of budget revisions.
4. Establish policies and procedures to ensure compliance with Subrecipient/Contactor provisions.
5. Document and report on compliance as specified by the Recipient/Grantee.

Property Standards

1. Develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source.

2. Establish and maintain policies and procedures that acknowledge the revisionary interest of the federal government over property improved or purchased with federal dollars.
3. Develop and maintain a current, complete, and accurate supply and medication inventory list.

Measures:

- List and schedule available to the Recipient/Grantee upon request.
- Documentation of these policies and procedures for Recipient/Grantee review.

Cost Principles

1. Ensure budgets and expenses conform to federal cost principles.
2. Ensure fiscal staff familiarity with applicable federal regulations.
3. Make available to the Recipient/Grantee very detailed information on the allocation and costing out of expenses for services provided.
4. Calculate unit costs based on historical data.
5. Reconcile projected unit costs with actual unit costs on a yearly or quarterly basis.
6. Have in place policies and procedures to determine allowable and reasonable costs.
7. Have in place reasonable methodologies for allocating costs among different funding sources and RWB categories.
8. Make available policies, procedures, and calculations to the Recipient/Grantee on request.
9. Have in place systems that can provide expenses and client utilization data in sufficient detail to calculate and determine reasonableness of unit costs.
10. Have unit cost calculations available for Recipient/Grantee review.
11. Participate in 340 B Pricing Program.

12. Use purchasing policies and procedures that meet federal requirements.
13. Establish policies and procedures that ensure contract requirements are met.
14. Provide detailed expense reports to enable the Recipient/Grantee to document that costs are at or below the cost of providing the drugs through ADAP.

Matching or Cost Sharing Funds

Subrecipient/Contactor, on behalf of the Recipient/Grantee, provides matching or cost sharing funds following the same verification process as the Recipient/Grantee.

Unobligated Balances

1. Report monthly expenditures to date to the Recipient/Grantee.
2. Inform the Recipient/Grantee of variances in expenditures.
3. Provide timely reporting of unspent funds, position vacancies, etc. to the Recipient/Grantee.
4. Establish and implement a process for tracking unspent RWB funds and provide accurate and timely reporting to the Recipient/Grantee.
5. Report any unspent funds to the Recipient/Grantee.
6. Carry out monthly monitoring of expenses to detect and implement cost-saving strategies.

Audit Requirements

1. Conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds).
2. Request a management letter from the auditor.
3. Submit the audit and management letter to the Recipient/Grantee.
4. Prepare and provide auditor with income and expense reports that include payer of last resort verification.

5. Prepare and provide auditor with 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.).
6. Financial policies and procedures guide selection of an auditor.
7. Policies and procedures available to Recipient/Grantee on request.
8. Comply with contract audit requirements on a timely basis.
9. Provide audit to Recipient/Grantee on a timely basis.
10. Provide Recipient/Grantee the agency response to any reportable conditions.
11. Comply with audit requirements A-133.

Quality Management Standards

The Subrecipient/Contractor participates in quality management.
This includes:

1. Identification of person(s) responsible for quality management.
2. Quality training for team leads.
3. QI activities aimed at improving client care, health outcomes and client satisfaction.
4. Performance measures.
5. QA.

Measure: Person(s) responsible and quality training for team leads noted at on-site monitoring

QI Activities

The Subrecipient/Contractor participates in QI activities:

1. Conducts QI related to client care, satisfaction or health outcomes.
2. Follows a structured methodology for conducting QI such as Plan-Do-Study-Act (PDSA).
3. Include at a minimum data collection, monitoring and quarterly reporting for QI projects.

Measures:

- Documentation of structured QI with a focus on improvement in client care, satisfaction or health outcomes related to service provided.
- Documentation of QI activities reported to UDOH quarterly, at a minimum.

Client Satisfaction

Client satisfaction evaluation is conducted annually at a minimum.

1. Subrecipient/Contractor establishes evaluation method to assess client satisfaction and quality of services. The following methods may be used:
   A. Satisfaction survey.
   B. Feedback request.
   C. Suggestion box or other client input mechanism.
   D. Focus groups and/or public meetings.
2. Subrecipient/Contractor uses results from evaluation to improve client satisfaction, quality of care or health outcomes.

Measures:

- Client satisfaction evaluation activities noted at on-site monitoring.
- Documentation of evaluation results used to improve satisfaction, quality of care or health outcomes.

Performance Measures

According to HRSA Policy Clarification Notice (PCN) #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 a RWB-funded service category	Minimum # of performance measures
≥ 50%	2
> 15% to < 50%	1
≤ 15%	0

1. HRSA strongly encourages the use of HRSA/HAB performance measures. For details of HRSA/HAB Performance Measures including rationale, inclusion, and exclusion criteria, refer to measure's portfolio online: HRSA Ryan White HIV/AIDS Program Performance Measure Portfolio.
2. The Subrecipient/Contractor monitors the required performance measure(s) on 100% of RWB clients and reports results to UDOH quarterly, at a minimum.

Measure: Documentation includes at a minimum data collection, monitoring and quarterly reporting to UDOH.

QA Monitoring

The Subrecipient/Contractor conducts monitoring to assure quality of care delivered. Results from monitoring may be used to identify and inform QI projects. The Subrecipient/Contractor is encouraged to use HRSA/HAB developed service related performance measures for QA and required performance measure

reporting. UDOH monitors Subrecipient/Contractor engagement with QA as a component of on-site monitoring.
Measure: Documentation the Subrecipient/Contractor conducts QA monitoring, and results are used to inform QI if indicated.

Monitoring Standards

Any agency or individual receiving federal funding is monitored to ensure compliance with federal requirements and programmatic expectations.

1. Monitoring activities include annual on-site monitoring of Subrecipient/Contractor.
2. Fiscal monitoring activities to ensure that RWB funding is being used for approved purposes.
3. Actions when monitoring or performance outcomes do not meet program objectives and Recipient/Grantee expectations may include:
   A. A “corrective action” letter.
   B. CAP(s).
   C. Progress on goals or CAPs.
   D. Sponsored TA.
   E. More frequent oversight.
   F. Redistribution of funds.
4. Salary Limit: HRSA funds may not be used to pay the salary of an individual at a rate in excess of $179,700. 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. This salary limitation also applies to sub-awards for substantive work under a HRSA grant or cooperative agreement.

5. Salary Limit 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.
6. Subrecipient/Contractor submit program, statistical, fiscal, and expenditure reports as outlined in UDOH contracts.

Measures:

- Documentation demonstrating consistent monitoring implementation following uniform administrative requirements governing the monitoring of awards.
- Documentation of UDOH monitoring including:
  A. Date of monitoring.
  B. Persons involved in monitoring.
  C. Administrative, quality management and service delivery monitoring.
  D. Review of policies and procedures.
  E. Review of tools, protocols, methodologies, and other identified reports.
- Documentation of UDOH monitoring including:
  A. Date of monitoring.
  B. Persons involved in monitoring.
  C. Review of fiscal monitoring policy and procedures, tools, protocols, monitoring reports.
  D. CAPs as indicated.
  E. Progress on goals or CAPs.
- Documentation of actions associated with monitoring activities ensure compliance with program objectives and Recipient/Grantee expectations. This may include:
  A. Approved CAP(s).

B. Report of CAP progress.

C. TA.

D. Redistribution of funds.

E. Other actions.

- Identification and description of individual employee salary expenditures to ensure salaries are within the HRSA Salary Limit.; determine whether individual staff receives additional HRSA income through other sub- awards.
- Identification of individual employee fringe benefit allocation.

Measure:

Records comply with Subrecipient/Contract reporting requirements.

Resources

- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards –Program Part B
- https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio
- https://hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/habpartbmanual2013.pdf
- https://hab.hrsa.gov/sites/default/files/hab/Global/fiscalmonitoringpartb.pdf
- https://hab.hrsa.gov/sites/default/files/hab/Global/HAB-PCN-15-02-CQM.pdf
- https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- https://ptc.health.utah.gov/wp-content/uploads/2021/03/2020-Utah-Ryan-White-Part-B-Program-Manual-FINAL-2020.04.01.pdf
- https://ptc.health.utah.gov/wp-content/uploads/2021/03/Final_Mar_2021_-RWBCQMPlan-1.pdf

Revise Date	Title of Reviewer	Change Description or Location
2022.06.23	ADAP Admin	Updated to DHHS Guidelines
2022.04.14	ADAP and Part B Admin	Added additional Billing requirements
2022.04.12	RN Quality Consultant and Quality Coordinator	Formatting, grammar and content updates. Added definition and measure for “employee self-care”, updated assigned Quality Section.
2022.03.01	ADAP Admin	Added Linguistic services under client polices, Add Vigorous pursuit documentation as proof of payer of last resort under Eligibility and Determination/Screening
2022.02.16	ADAP Admin Part B Admin and ClientTrack Admin	Review for content updates

Approval Group	Review Date
Part B Administrator: Seyha Ros	2022.02.16
ADAP Administrator: Allison Allred	2022.03.01
ClientTrack Administrator: Summer Bammes	2022.02.16

Quality Coordinator: Marcee Mortensen	2022.04.12
Senior RN Quality Consultant: Vinnie Watkins	2022.04.12
Fiscal Analyst III: Anna Packer	2022.03.25
Financial Manager I: Derrick Blomquist	2022.03.25
RWB and HIV/STD Prevention Manager: Tyler Fisher	2022.09.15
Director, Office of Communicable Disease: Sam LeFevre	2022.09.15