

**District of Columbia Department of Health
HIV/AIDS, Hepatitis, STD and Tuberculosis Administration (HAHSTA)**

**RFA # RW_A&B03.29.13
Questions & Answers
Release Date: 04.30.13**

The following questions were obtained from prospective applicants who had questions specific to the Request for Applications (RW_A&B03.2913) released on 03.29.13, as well as general questions regarding the planned future initiative known as: "Retention for Results: Towards Durable Viral Suppression in the District of Columbia." RFA # RW_A&B03.2913 is officially amended by the addition of this "Q&A," which shall be known as Appendix B.

General Questions

1. What is the time period for questions and answers for RFA # RW_A&B03.29.13?

The deadline for submission of questions remains May 9, with a final written set of responses to be distributed no later than May 14, 2013.

Note: this set of questions and answers includes all those received by April 16, 2013.

2. For applicants applying under two different tiers what do we need to provide?

A complete application is required for each tier.

3. May applicants include in their requested funding support for one or more case workers?

Yes. See the description of "community health workers" on page 10 of the RFA.

4. What is the relationship between RFA # RW_A&B03.29.13 and the priorities set by the Planning Council?

The projected funding levels reflect the Part A priorities and allocations of the Planning Council, based on estimates of award.

Tiers

5. Shall an applicant apply for all service areas with funds in the Tier for which they are applying?

Applicants may apply for funding to support the service, or describe how they will otherwise meet the service needs of their proposed clients.

- 6. My organization serves clients who do not have any need for one or more service categories. Tier One and Tier Two applicants are asked to describe their plan to meet a wide range of service needs. Does that mean I cannot apply under Tier One or Tier Two?**

No. Applicants should address each service category, but may offer an explanation as to why one or more service categories are not needed by their proposed clients. Applicants are advised to describe contingency plans in the event of an unexpected service need.

- 7. What impact will the impact of this tier system have on the eligibility requirements of any given provider?**

The eligibility criteria included in this RFA are specific to services supported by Part A and Part B funds, and are not different from those currently in place. Individual providers may have other funding sources – including privately raised funds – and may choose to establish different eligibility criteria for clients served through different funding sources.

A. Partners in Care (PIC)

- 8. What is the difference between PIC and MOUs?**

A “partner in care” is an organization. A “Memorandum of Understanding” is an agreement between two organizations, and in this case governs the mutual obligations and expectations of the partners in care.

- 9. Are there specific service categories that require PIC agreements or under which PIC agreements are preferred vs. MOUs? Please clarify.**

Any arrangement with another organization to provide a service must be documented in a Partner in Care agreement.

- 10. Can partners (that is, organizations not applying under Tier One or Tier Two) make partnership agreements with only one Tier One or Tier Two lead provider?**

No. Any “Partner in Care” may execute partnership agreements or MOU with multiple Tier One or Tier Two applicants.

- 11. Is it permissible for a Tier One or Tier Two awardee to have multiple Partners in Care for the same service category?**

Yes. The Partnerships are designed to ensure responsiveness to client needs, and the needs of clients of a Tier One or Tier Two awardee may be best met through partnerships with a specific organization.

- 12. Can an individual be served by more than one Tier One or Tier Two network?**

See the section of the RFA “Client Cohort and Co-Management” for a brief discussion of the expectation that awardees will work diligently towards eliminating duplication of services, while at the same time identifying a limited number of circumstances in which some duplication may be critical to meet the needs of clients.

A goal of this RFA is to develop service delivery systems that meet the full range of client needs, and eliminate the need of seeking core medical or support services outside the Tier and its partners.

13. Which organization is responsible for ensuring eligibility?

Awardees are responsible for ensuring that all clients served either directly or indirectly by a Partner in Care is eligible for the services.

14. Is “eligibility screening” the same as “assessment?”

“Eligibility screening” is used to describe activities to determine client information relevant for eligibility for services, including income, insurance status, location of residence, HIV infection and the like. “Assessment” is more often used to describe activities designed to understand and respond to a one or more service needs.

15. It is permissible to change partnership agreements after award?

Yes. The RFA includes a requirement that partnership agreements include an evaluation component, and at least some adjustment is expected as unforeseen difficulties arise and are addressed.

16. Shall partners report services to each of the Tier One and Tier Two awardees, or will partners report to HAHSTA?

Tier One and Tier Two awardees shall report to HAHSTA, and shall also be responsible for ensuring and reporting the delivery of services provided through partners. HAHSTA will offer technical assistance to awardees to ensure consistency and minimize reporting burden.

17. What is the recommended course of action for partners when a client moves from a Tier One or Tier Two awardee to an organization with which the partner does not have a “Partner in Care” agreement?

All Tier One and Tier Two awardees are required to demonstrate their ability to provide, directly or indirectly, a range of services. In the event that a client moves within Tier One or Tier Two providers, the disruption of services should be minimized.

The RFA encourages Tier Two providers to develop partnerships with providers of ambulatory outpatient medical care that are not funded through this RFA, and will serve to ensure continuity of services for those clients.

18. How do clients qualify for services if they are not referred by a Tier One or Tier Two provider? How do clients currently served by a partner that will not receive Tier One or Tier Two funding qualify for CARE Act-funded services solicited under this current RFA?

Generally, clients will not be eligible for CARE Act funded services if they are not enrolled through a Tier One, Tier Two or Tier Three provider. Providers with multiple funding sources – including privately raised funds – have alternate ways of supporting these services.

19. How are reimbursement rates set? Are these rates uniform among Partners in Care agreements?

See the section “Partners in Care” in the RFA, and especially page seven.

20. How does a partner ensure that services are of consistently high quality under separate partnership agreements?

A single standard of services is required of all awardees, and their partners. Activities and costs incurred to ensure that standard of services should be included in the partnership agreement.

B. Tier One

21. The RFA requires a minimum case load of one hundred and fifty clients for Tier One applicants. Is it limited by funding source or geography?

The case load minimum is intended to describe the experience of the provider and applicants should include all ambulatory outpatient medical clients with HIV regardless of payor source or residence.

22. Follow-up to question B.21 above: Does this include primary care clients with HIV only?

See the revised RFA Section “Tier One: Primary Care and Care Coordination” for the addition below:

- *Potential applicants for Tier One with a current case load of fewer than one hundred and fifty primary care clients with HIV may propose under Tier One. All Tier One awardees will be required to provide ambulatory outpatient medical care and medical case management directly, so applicants should clearly describe their agency’s experience with HIV clinical care (including clinical care other than primary care), capacity, timeline and plan to provide HIV primary care and medical case management.*

23. Are Tier One applicants required to apply for any other services other than Outpatient Ambulatory and MCM?

Tier One proposals should describe the plan for ensuring that all services needed by their clients are met. Tier One applicants may request funding for each of those services for

which funding is available, and may also propose to enter into partnerships with other organizations to provide any of the services other than ambulatory outpatient medical care and medical case management.

24. What dates should we reporting past performance against?

- a. page 50 - grants and programs level compliance, Oct 1 2011- Dec 31 2012, a 14 month range for grants performance, does not coincide with the contract year
- b. page 47 - Jan 1 – Dec 31 2012 success in retention indicators
- c. page 30 - July 1 2011 – June 20 2012 success with the same retention indicators

Please see the revised RFA. In response to “a.” the revision is:

Criterion C:HAHSTA Past Performance (No Points Awarded)

Grant and program level of performance on activities funded by any HAHSTA program (October 1, 2011 – December 31, 2012 funded and concluded during calendar 2012. This will include sub-grants funded by DC Fiscal Year 12 (October 1, 2011 – September 30, 2012), Part A Grant Year 21 (March 1, 2011 – February 28, 2012) and Part B Grant Year 21 (April 1, 2011 – March 31, 2012).) Past Performance will be considered but not scored when reviewing applications.

There is no change in response to “b.” Item “c.” has been deleted from the revised RFA as redundant.

25. Given that the goal of the RFA is to maximize enrollment in insurance programs and have RW serve to fill gaps, how should we represent our primary medical targets for Tier One? Should we include all our projected DC clients, regardless of funding stream for medical services, and also then represent the projected program income? Or are we supposed to project the number of clients that will be in need of stop gap services?

Applicants are asked to propose “whole programs.” Most clients with a third-party payor source – including Medicaid or private insurance – are legitimately part of the CARE Act funded “whole program” provided that

- *The CARE Act funds reimburse for direct costs, usually the salary and benefits of direct service staff*
- *The organization bills, collects and reports third-party payment*
- *The organization returns third-party payment as “program income” to benefit the HIV program.*

In preparing your application, you should propose a “whole program” and include all clients served by it.

C. Tier Two

26. Is there a minimum caseload requirement for Tier Two applicants?

No

D. Tier Three and Tier Five

27. What income eligibility criteria should be used for providers of services EMA-wide?

Awardees will use the most inclusive income eligibility requirement among the subdivisions of the EMA.

28. What distribution of services does HAHSTA expect for services under Tier Five?

See “Psychosocial Support Services” under Tier 5 in the RFA for additional information on the distribution of this service by target population and geography.

29. Are there additional eligibility criteria for clients served under Tier 3?

Yes. Please see the revised RFA section “Tier Three: MAI Cluster” of the RFA.

In addition, services supported through Tier Three are intended for services to high-need clients. Criteria used to estimate “high-need” are

- | | |
|---|--|
| <i>a. Very low income</i> | <i>d. Homelessness, recent history of homelessness, or imminent homelessness</i> |
| <i>b. Limited experience with health care</i> | <i>e. Mental illness</i> |
| <i>c. Non-adherence to treatment services, including high likelihood of non-adherence to medications.</i> | <i>f. Substance abuse</i> |

E. Tiers and Fiscal Management

30. What are HAHSTA expectations regarding fiscal management of partnerships?

The Awardee shall be the fiduciary agent, and therefore responsible for ensuring the partners’ compliance with all applicable federal and local laws and regulations. This includes the Awardee’s responsibility for ensuring that all requirements of the sub-grant agreement are appropriately put into place with respect to partners in care.

31. Do the “sliding fee scale” requirements of the CARE Act apply to clients receiving non-clinical services?

HAHSTA policy and guidance is to meet the “sliding fee scale” requirements by charging clients a nominal fee per visit for primary care services only.

Service Categories

F. AIDS Drug Assistance and AIDS Pharmaceutical Assistance (Local)

32. AIDS Drug Assistance Program and AIDS Pharmaceutical Assistance (Local) are listed as services to be supported, but do not have any funding available under this RFA. How should applicants respond?

All applicants under Tier One, Tier Two and Tier Three should describe their plan to ensure that their clients are screened and enrolled in appropriate programs that support AIDS drug assistance. Funds to support these services may be available from other sources, and are not included in the funding available under this RFA.

G. Health Insurance Continuation and Premium Assistance

33. Table 1 lists this category as “Direct or Indirect” for Tier One and Tier Two. Table 2 lists no funding for either Tier One or Tier Two, but includes funding available under Tier 4. Which is correct?

This category is offered as an indirect service only for Tier One and Tier Two. It is offered as a direct service under Tier Four. The available funding in Table 2 is correct. Please see the amended RFA Table 1.

H. Early Intervention Services

34. Do Tier One providers need to provide this? It says EMA-wide but no funds are allocated under Tier Three? Please clarify.

This category is among the services for which Tier One and Tier Two awardees will be responsible to provide directly or indirectly. It is not included in Tier Three.

Early Intervention Services are the core activity of Tier Five, and is provided to clients throughout the Eligible Metropolitan Area.

35. Isn't it a contradiction to say that one has to show people who are HIV positive but RW doesn't fund testing?

No. CARE Act funds may be used to support services to people with HIV, and each person served is required to have documentation of HIV infection.

I. Hospice

- 36. Hospice services are listed in the core services on page 3 and in Attachment N: Medicaid Eligibility Chart as one of the “service categories funded under this RFA,” but they are not found in Table 1 or Table 2. Are these services funded and, if so, in which tier are they included and how will they be funded and at what level?**

Hospice services are among the Core Medical Services permitted in the CARE Act, but no funds are allocated for this service category.

Attachment N accurately lists Hospice Care as a Medicaid-supported service..

J. Home and Community Based Care

- 37. Are all Tier One providers expected to provide home and community-based care?**

All Tier One providers are expected to identify the needs of their clients with respect to home and community-based care services, and the strategies they will use to meet those needs. Those strategies may include a partnership agreement to provide the service.

Tier One and Tier Two applicants are asked to describe their plan to meet the needs of their current and proposed clients, and may include an explanation that one or more service categories is not needed by their current and proposed clients. Those that serve clients with this service need may apply for funding to support it, and offer the service through a partner in care.

- 38. Table 1 lists home and community-based care as a required service for Tier Two providers, but Table 2 shows no funding for this category in Tier Two. How will the services be paid for in Tier Two?**

Tier Two awardees are responsible for a small group of clinical services – including Home and Community-Based Care – for which there is no funding managed through Tier One. These services will be supported through an established relationship with one or more Tier One providers.

- 39. If an individual being served by one Tier One or Tier Two network is referred to an agency that is part of another Tier One or Tier Two network for a specific service (i.e., Home and Community-Based Care) can that individual remain a client of the original referring network for their primary services?**

Each Tier One and Tier Two network are responsible for all services included in this RFA, and may provide them directly or indirectly.

K. Medical Case Management

40. This service category is available under multiple Tiers. Are there differences among the service requirements?

No. A single standard of care governs all medical case management activities and services, and is described in the "HIV Medical Case Management Guidelines."

41. Is it permissible to fund a nurse case manager under this service category?

Yes.

42. What are Medicaid requirements regarding Medical Case Management?

Medicaid requirements and guidelines vary from state to state, and applicants are responsible for understanding all applicable Medicaid programs and propose services consistent with those requirements.

Applicants are advised to review the services called "medical case management," because the range of services supported can vary widely, and in some cases, supports only a narrow range of services, for example, enrollment into entitlement programs.

L. Home Delivered Meals and Medical Nutrition Therapy

43. Funding is split between Tier One and Tier Two. Which of these tiers applies to Home Delivered Meals and Medical Nutrition Therapy?

Tier One and Tier Two awardees are required to provide a range of services, including Home Delivered Meals and Medical Nutrition Therapy, and can propose to propose meeting those needs by a partnership with one or more providers of Home Delivered Meals or Medical Nutrition Therapy

This RFA does not include the opportunity to apply for Home Delivered Meals or Medical Nutrition Therapy independent of the Tiers.

M. Linguistic Services and Emergency Financial Assistance.

44. The monitoring requirements in Attachment G for Linguistic Services includes the percentage of clients who have had two or more medical visits in an HIV care setting in the measurement year. Is there some other way to measure how these vital support services are supporting treatment adherence, without putting a reporting requirement that will probably require us to add additional layers of information for the providers, and possibly delay access to the service?

See the section above on “Partners in Care.” A partnership agreement between a Tier One or Tier Two provider and a Tier Four provider could include exchanging information on the medical visits and other health status indicators.

Partnerships are intended to increase the efficiency of data collection rather than require each partner to collect all necessary data. All support services should be demonstrated as contributing to improved health status.

N. Medical Transportation Services

45. How is the service to be provided?

This service category supports the costs of client transportation to core medical or support services. See the “Compendium of Services” for a discussion of medical transportation.

O. Funding Sources: Part A and Part B

46. Will HAHSTA designate Part A and Part B funds to Tier One and 2 awardees? Or will all Part B funds be directed to Tier Two grantees?

All services supported under this RFA are permissible for Part A or Part B. HAHSTA will designate Part A or Part B funds in its award process. Tiers Three and Five are funded by Part A only.

All new sub-grants supported by Part A and Part B begin October 1, 2013.

47. If Tier One grantees will be awarded Part B funds and we are a current Part B grantee, then how do we demonstrate these costs? Do we fold them into the MCM service category costs under the Tier One?

Applicants should apply for one or more Tiers without regard to the funding source that may support it.

48. Where do we speak about our experience as a Part B funded organization? “Organizational Capacity?” “Program Description?”

Applicants should describe their capacity and proposed program without respect to a specific funding source.

P. Data Reporting

49. Will “Partners in Care” be responsible for putting information into CAREWare?

Awardees are responsible for data reporting. All partnership agreements should define roles and responsibilities of the partners, and sharing of data may achieve good efficiencies.

50. Is it permissible to use funding under this RFA to support data collection and reporting?

Yes. The costs of data collection and reporting may be included by the allowable administrative and indirect costs, as well as the program support costs.

Q. Attachments

51. Attachment A confirms the order of the elements checklist however page 28/29 provide different descriptions for what is required within each application element. Can you confirm which sections the element descriptions starting on page 29 fall under?

Please see the revised RFA and Attachments.

52. Attachments D/G. What is the grant cycle we should be proposing targets for these two attachments?

Applications are expected for a twelve-month grant period. HAHSTA expects to award a partial year award (five or six months) with two optional twelve-month awards.

53. Attachment E – Do applicants need to provide copies of MOUs with our application or after we have been awarded funds?

MOU are not required for Attachment E. However, the RFA does encourage documentation of existing or expected partnerships to carry out the proposed program. Reviewers will assess the likely success of the proposed program in part on the basis of identified partnerships.

R. Budget

54. What is the budget format?

The budget format is available on the web location listed in the section “Budget and Budget Narrative” on page 45 of the RFA.

55. Do applications include a separate budget for each service category?

Yes. See “Application Submission” on page 46 of the RFA.

S. Application Submission

56. Please confirm the number of copies needed for Tier One and Tier Three.

Each Tier requires a separate and complete application. Each application includes one printed original, three printed copies and one copy on a jump drive.

57. Are “Assurances” required for the applicant only? Or are they required of each partner in care?

For the purposes of responding to the RFA, assurances are required only of the applicant organization. Awardees will be responsible for compliance of all relevant requirements by partners in care, and HAHSTA may require submission of assurances by partners in care as a condition of award.

58. What is the time period for “Clean Hands” and other Assurances?

All Assurances must be current and in effect as of the Application Due Date for this RFA, May 23, 2013. Awardees – and current grantees and sub-grantees of HAHSTA – are responsible for updating their assurances upon expiration.

T. Review Criteria

59. Which review criteria sections correspond to application element sections?

Please see the revised RFA, which has consistent naming conventions and revised distribution of points.

HAHSTA has re-considered the assignment of points per section, and is implementing a review that uses the following distribution:

<i>Agency Experience</i>	<i>25 points</i>
<i>Program Description</i>	<i>75 points</i>
<i>Care and Service Coordination</i>	<i>75 points</i>
<i>Monitoring and Evaluation</i>	<i>25 points</i>
<i>Quality Management</i>	<i>25 points</i>
<i>Total</i>	<i>225 points</i>

Other Questions

60. Will HAHSTA provide the number of current Tier One and Tier Two sub-grantees?

Current HAHSTA sub-grants are not organized into Tiers. HAHSTA currently awards sub-grants that include ambulatory outpatient medical care to twelve organizations. In addition, HAHSTA currently awards sub-grants that included medical case management – but not ambulatory outpatient medical care – to seven organizations.

61. Will HAHSTA provide a list of current providers? Will HAHSTA provide a list of attendees of the pre-application conference?

A copy of the current providers of HIV/AIDS services funded by Ryan White Part A and Part B funds may be found on the DOH website at www.doh.dc.gov. Locate it under Services/Grant Funding and scroll to the bottom of the page to link to provider lists. Note: page is subject to change as new awards are added.

The list of attendees of the pre-application conference is not available for distribution.