Common Standards of Care

Standard I Documentation & Eligibility Screening: The following information should be in all participant charts and will be checked during site visits. Agencies should not use participant self reports for any required documentation. [1]

Requirement	Indicator	Data Source
Providers will ensure appropriate screening and reassessment of all participants to determine eligibility.	Verification of the participant's HIV status should be from a medical provider (i.e. lab work results or a letter on letterhead signed by medical staff personnel).	**Participant's file** contains confirmation of HIV status. This must be confirmed at initiation of services.
	Participant must qualify as low income, less than or equal to 400 percent of Federal Poverty Level. [2]	**Participant's file** contains paycheck or stub, bank statement, or other adequate proof. If the participant is reporting no income, then the provider must document how the participant is subsisting. This must be confirmed every six months.
	Participant must demonstrate insurance status including: • Uninsured or underinsured status. • Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare. • For underinsured, document the participant's ineligibility for service. • Veterans receiving VA health benefits are considered uninsured, thus exempting these veterans from the "payor of last resort." requirement	**Participant's file** contains proof of insurance, underinsured, or documentation of ineligibility for third party insurance including Medicaid and Medicare. This must be confirmed every six months.

[1] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part I: Universal Standards (Draft August 2010)-Section B; RW Part B 2616(B): Part A and B Guidance

[2] 400% is not proscribed by HRSA. This number was chosen to match the current Part B income limit for insurance and ADAP.

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Requirement	Indicator	Data Source
	Participant can demonstrate residence within the Denver Transitional Grant Area (TGA).	**Participant's file** contains any of the following documents with address and participant's name: bill, copy of a current lease, or letter from Social Security. In the case of participants who are homeless, the provider needs to document how the participant is subsisting. Document must be current and must contain the participant's name. This must be confirmed every six months.
	Document that all staff involved in eligibility determination have participated in a comprehensive training in eligibility determination requirements.	**Personnel file** of all staff involved in eligibility determination demonstrates that he/she has completed a comprehensive training in eligibility determination requirements.
	Ensure agency client level data reporting is consistent with funding requirements, and demonstrates that eligible participants are receiving allowable services.	**Participant's file and CAREWare** data demonstrate that participants receive only allowable services.
Every participant's legal name will be documented and used in the creation of the eURN in CAREWare.	Providers are to use the participant's legal name attained from a government issued document in all documentation and in data entry in CAREWare.	**Participant's file** contains copy of a government issued document showing legal name (e.g. driver's license, social security card). This must be confirmed at initiation of services.
Every participant file will have documentation of a Signed Grievance Procedures.	Each participant should sign the provider's grievance procedure.	**Participant's file** contains a copy of the grievance procedure, or other documentation that the participant has received the procedures, is signed by the participant.

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Standard II Access to Care: Participants should be supported in having system-wide access to services; barriers to service should be eliminated.[3]

Requirement	Indicator	Data Source
Providers shall eliminate barriers to service and ensure provision of services in a setting accessible to low-income individuals with HIV.	Medical care, pharmaceuticals, case management and home health care shall provide a minimum of 40 hours access to services per week including after 5:00 p.m. and weekends as appropriate.	**DOHR Contract** will include the Scope of service description, and the hours of service will be posted in a prominent place within the agency.
	Providers must have a full range of service referrals available. To establish this base of referrals, providers need to network with other AIDS service organizations and prevention programs as well as city, state, and private organizations providing similar or complimentary services in the community.	**Provider's Procedures** demonstrate that the provider effectively networks with other service providers when needed, and has established a full range of service referrals.
	Provider will comply with Americans with Disabilities Act (ADA) requirements.	**Provider's files** will document ADA complaints and grievances, with documentation of complaint review and decision reached.
	Appropriate accommodations shall be made to meet language or other needs such as illiteracy, visual or hearing impairment.	**Provider's Policies and Procedures** demonstrate how they provided services to those needing special accommodations.
	Provider will ensure that the facility is accessible by public transportation or provide for transportation.	**Site visit** inspection of agency facility.

[3] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part I: Universal Standards (Draft August 2010)-Section A; RW Part A 2605 (a)(7)(A-C); RW Part B 2617 (b)(7)(B)(i-iii); RW Part B ADAP 2616(c)(4-5); 2602(b)(2)(G); 2617(b)(7)(A)

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Requirement	Indicator	Data Source
	Providers will document efforts to inform low-income individuals of the availability of HIV-related services and how to access them. Provider will maintain file documenting agency activities for the promotion of HIV services to low- income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements.	**Provider's Files** will document agency activities for the promotion of HIV services to low- income individuals.
Provider shall implement structured and ongoing efforts to obtain input from participants in the design and delivery of services.	Provider will maintain file of materials documenting Consumer Advisory Board (CAB) membership and meetings, including minutes.	**Provider's Files** demonstrate CAB membership and meeting minutes.
	Provider will maintain visible suggestion box or other participant input mechanism.	**Site visit** inspection of agency facility.
	Provider will implement participant satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented annually.	**Provider's Files** demonstrate implementation of satisfaction survey tool, focus groups, and/or public meetings including analysis and use of results.
Provider shall allow for the provision of services regardless of an individual's ability to pay for the service.[4]	Provider will have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services regardless of the participant's ability to pay.	**Provider's Policies and Procedures** document their billing, collection, co-pay and sliding fee policies and that they do not act as a barrier to providing services regardless of the participant's ability to pay.

[4] Confirm that this is limited by the income guidelines in the Eligibility Standard.

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Requirement	Indicator	Data Source
	Provider will maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.	**Provider's files** will document individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.
Providers will ensure provision of services regardless of the current or past health condition of the individual to be served	Eligibility Policies and Procedures state that services are provided regardless of pre-existing conditions.	**Provider's Policies and Procedures** will document that services are provided regardless of pre-existing conditions.
	Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.	**Provider's files** will document individuals refused services with reasons for refusal specified; include in file any complaints from participants, with documentation of complaint review and decision reached.

Standard III Staff and Volunteer Training & Qualification: The provider's staff have sufficient education, experience, and skills to competently serve the HIV/AIDS participant population.

Requirement	Indicator	Data Source
Staff members/volunteers will have a clear understanding of their job definition and responsibilities.	Written job descriptions will be on file and signed by the staff or volunteers.	**Personnel/Volunteer file** contains signed job description**.**

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Requirement	Indicator	Data Source
Staff members will receive structured supervision from qualified supervisors.	Every employee working directly with participants will receive supervision on both clinical and job performance issues. Providers should complete a standardized performance evaluation for each staff member at least annually.	**Personnel file** contains clinical and/or job performance evaluations for employees who have been with the provider for a year or more**.**
Staff and supervisors are qualified to provide the necessary services to participants.	Staff and Supervisors have the appropriate licensure, education and experience.	**Personnel file** has proof of licensure and/or education appropriate for the specific position**.**
Initial orientation and training shall be given to new direct service staff.	Initial orientation and training should include at least 20 hours of training during the first 6 months of employment on the following: cultural competency, basic HIV/AIDS information, Ryan White Care Act Part A services and other funding sources, provider's policy and procedures, other government programs, psychological issues, and standards and requirements. Training can be internal and external to the organization.	**Personnel File** demonstrates the type, amount (minutes or hours) and date of orientation and training each staff receives both internally and externally.
Staff should receive the following training annually.	Every staff handling confidential information will receive an annual training concerning HIPAA and Confidentiality.	**Personnel file** demonstrate the type and amount of training each staff received both internally and externally.
	Every staff receives annual training on OSHA regulations and Universal Precautions.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.

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Requirement	Indicator	Data Source
	Every direct care staff receives 20 hours of job specific professional development training annually.	**Personnel file** demonstrates the type and amount of training each staff received both internally and externally.
Each provider has a volunteer training program appropriate to support each volunteer position.	Initial orientation and training for volunteers working directly with participants must be completed prior to working directly with participants and should include at a minimum the following: cultural competency, basic HIV/AIDS information, basic participant contact skills, HIPAA and confidentiality and provider's policy and procedures.	**Volunteer file** demonstrates the type and amount of orientation the volunteer received.
Staff or volunteers working with participants are to be screened in accordance with state and local laws.	Background checks must be obtained as required by state and local laws.	**Personnel or Volunteer file** contains background checks.
Staff or volunteers transporting participants will have a valid Colorado driver's license and proof of insurance.	Providers will ensure that they have a current valid driver's license and current insurance information for each staff or volunteers who transports participants.	**Personnel or Volunteer File** contains a copy of a valid driver's license for those staff or volunteers who transport participants.

Standard IV Quality Assurance: Providers are responsible for on-going Quality Assurance programs to improve funded programs, as well as to offer regular feedback to staff to help promote performance improvement and quality care.

Requirement	Indicator	Data Source
Each provider will have written policies on Quality Management, including how data will be used to improve each funded program.	Each provider will collect participant level data to support CAREWare reporting and other data reports as indicated.	**Reports from the Denver Office of HIV Resources** will be completed accurately and on time.

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Requirement	Indicator	Data Source
	Each provider will adopt a quality improvement system (Chronic Care Model or other) to guide work plans and other quality management activities.	**Provider's Reports** documents the use of a quality improvement system.

Standard V Confidentiality: Providers must have systems in place to protect confidentiality according to best practices and applicable regulations.

Requirement	Indicator	Data Source
Providers shall have written Policies and Procedures addressing participant confidentiality which are compliant with HIPAA.	Policies and Procedures should address HIV/AIDS-related confidentiality and provider procedures, including those limiting access to passwords, electronic files, medical records, faxes, and release of participant information	**Provider's Policies and Procedures** on confidentiality.
	Policies and Procedures are signed and dated by staff during orientation	**Personnel file** has a signed statement by each staff that the staff has read and understood the provider's policies and procedures regarding confidentiality.
	Major changes in policies and procedures are presented to all the staff they impact	**Personnel file** indicates that staff have been trained on any major changes to policies and procedures.
The Provider's physical set up ensures that services are provided in a private area.	Areas in which participant contact occurs allow exchange of confidential information in a private manner	**Site visit** inspection of agencies facility.
All hard copy materials and records shall be securely maintained by the Provider.	Records, hard copy materials maintained under double lock (in locked files and in locked areas) secure from public access.	**Site Visit** observation**.**

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Requirement	Indicator	Data Source
	Each computer is password protected and staff/volunteers must change passwords every six weeks.	**Provider's Policies and Procedures** on confidentiality demonstrates compliance.
All participants shall be informed of their rights to confidentiality at intake.	Documentation signed and dated by participant acknowledging participant was informed of his/her right to confidentiality.	**Participant's file** contains a signed statement that the participant was informed of their rights confidentiality at intake.
There should be no release of participant information without a signed, dated participant release.	There should be a signed, dated Release of Information form specific to HIV/AIDS, TB, STD, substance abuse, mental health and any other confidential information prior to the release or exchange of any information.	**Participant's file** contains signed releases appropriate to the services provided and information needed.

Standard VI Anti-Fraud, Anti-Kickback: Providers must have systems in place to avoid fraud, waste and abuse (mismanagement).[5]

Requirement	Indicator	Data Source
Providers must demonstrate structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally funded program.	Medicare/Medicaid providers must have a Corporate Compliance Plan.	**Provider's Policies and Procedures** document the Corporate Compliance Plan (Medicare/Medicaid providers only).
	Providers must have a documented Code of Ethics or Standards of Conduct.	**Provider's Policies and Procedures** document their Code of Ethics or Standards of Conduct.
	Non-profit providers must have bylaws and board policies.	**Provider's Policies and Procedures** document board bylaws and policies.

[5] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part I: Universal Standards (Draft August 2010)-Section C; 42 USC1320a; 42 USC13207b(b); Part A and B Notice of Grant Award Standard Terms; Part A and B Assurances

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Requirement	Indicator	Data Source
	Providers must maintain a file documenting any complaint of violation, or actual violation, of the Code of Ethics or Standards of Conduct by an employee or board member.	**Provider's files** will document any employee or Board Member violation of the Code of Ethics or Standards of Conduct.
Providers will document how employees (as individuals or entities) are prohibited from soliciting or receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other federally funded program>	Providers will maintain documentation of: • Service contracts that discourage agency payments for service referral. • Key employee background checks. • Recruitment practices that prohibit exorbitant signing bonuses. • Audit findings on internal controls. • Procurement policies with conflict of interest clauses. • Prohibition of higher charges for Medicare/Medicaid services. • Compliance audits or compliance checks.	**Provider's Policies and Procedures and Files** document the prohibition for receiving remuneration for inducing referrals of items or services covered by Medicare, Medicaid, or any other federally funded program
Providers will document how employees (as individuals or entities) are prohibited, from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.	Have adequate policies and procedures to discourage soliciting cash or in-kind payments for: • Awarding contracts. • Referring participants. • Purchasing goods or services and/or • Submitting fraudulent billings.	**Provider's Policies and Procedures** discourage soliciting cash or in-kind payments.

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Requirement	Indicator	Data Source
	Have employee policies that discourage: • The hiring of persons with a criminal record. [6] • The hiring of persons being investigated by Medicare or Medicaid. • Large signing bonuses.	**Provider's Policies and Procedures** document hiring process.
Providers offering Medicaid/Medicare billable services, will document that they have a Compliance Plan/employee standard of conduct that distinguishes and describes conduct that merits agency penalties from conduct that represents a possible felony.	Provider will have in place policies and procedures that: • Delineate penalties and disclosure procedures for conduct deemed to be felonies. • Include and describe the safe harbors[7] laws. • Include the reporting of non-compliance with the policy.	**Provider's Policies and Procedures, Compliance Plan, Employee standard of Conduct** will address consequences for non-compliance.
Requirement that any Compliance Plan and/or employee standard of conduct describe conduct that merits exemption from anti-kickback regulations (safe-harbors) .	Provider's anti-kickback policy must include the implications, appropriate uses, and application of safe harbors. Information is found in the compliance plan/employee standards of conduct that describes practices that are exempt from prosecution; included are: • Some investments in ambulatory surgical centers • Agencies in under-served areas that: ▪ Enter into Joint Ventures ▪ Have practitioner recruitment plans	**Provider's Policies and Procedures** include the implications, appropriate uses, and application of safe harbors.

6 The HRSA doc cites 42 U.S.C. 13207b(b) for this requirement. I don't see how they come to this specific requirement. http://www.law.cornell.edu/uscode/uscode42/usc_sec_42_00001320---a007b.html

7 Safe Harbor is a legal provision to reduce or eliminate liability as long as good faith is demonstrated.

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	▪ Sell physician practices to hospitals ▪ Give subsidies for obstetrical malpractice insurance ▪ Have specialty referral arrangements between providers • Cooperative agreements with 501(e) hospitals	

Standard VII Limitation on, and Unallowable Uses of Part A Funding: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Sections A and B. [8]

Requirement	Indicator	Data Source
Provider will prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses	Budget is prepared with sufficient detail to identify administrative expenses.	**Provider's DOHR Contract Budget** provides sufficient detail to identify administrative expenses.
	Expenditure reports are prepared with sufficient detail to identify administrative expenses.	**Providers Monthly Invoices** to DOHR provide sufficient detail to identify administrative expenses.

[8] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Sections A and B; RW Part A 2604 (H)(3) A-B; Part A Manual II 2 A-B; RW Part A 2604(h)(4) A-B; RW Part A 2604 (i); RW Part A 26504 (i); RW 2684 General Provisions; Conditions of Notice of Grant Award; DSS Outreach Policy; Part A Manual; 45CFR 93; Conditions of Notice of Grant Award; Parham letter 2.3.09

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Requirement	Indicator	Data Source
Providers will have appropriate systems in place to assure compliance with Ryan White unallowable cost policy.	All budgets and expenses will be tracked in sufficient detail to document that they do not include the following unallowable costs: 1. No uses of Part A funds to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility, (other than minor remodeling). 2. No cash payments to service recipients 3. No use of Part A funds to develop materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual. 4. No use of Part A funds for the purchase of vehicles without written Grants Management Officer (GMO) approval 5. No use of Part A funds for: • Non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.) • Broad-scope awareness activities about HIV services that target the general public 6. No use of Part A funds for outreach activities that have HIV prevention education as their exclusive purpose 7. No use of Part A funds for influencing or attempting to influence members of Congress and other Federal personnel ~~1.~~8. No use of Part A funds for foreign travel	**Providers DOHR Contract Budget and Monthly Invoices** will be tracked in sufficient detail to document that they do not include the identified unallowable costs.

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Standard VIII Income from fee for services: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section C.[9]

Requirement	Indicator	Data Source
Providers must document the use of Part A and third party funds to maximize program income from third party sources and ensure that Ryan White is the payor of last resort. Third party funding sources include: • Medicaid • State Children's Health Insurance Programs (SCHIP) • Medicare (including the Part D prescription drug benefit) and • Private insurance	Have policies and procedures documenting the requirement that Ryan White be the payor of last resort and how that requirement is met.	**Provider's Policies and Procedures** document the requirement that Ryan White be the payor of last resort and how that requirement is met.
	Provide staff training on the requirement that Ryan White be the payor of last resort and how that requirement is met.	**Personnel file** indicates that staff have been trained on Ryan White payor of last resort policies and procedures.
	If a participant is eligible for insurance or third party programs they are assisted applying and referred appropriately.	**Participant's file** documents they have been screened for insurance coverage and eligibility for third party programs, and helped to apply for such coverage.
	Carry out internal reviews of files and billing system to ensure that Ryan White resources are used only when a third party payor is not available	**Provider Files and/or Participant's file** will document an internal review process which ensures that Ryan White resources are used only when a third party payor is not available.
	For medical providers: establish and maintain medical practice management systems for billing	**Provider's Medical Practice Management System for billing.**

[9] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section C; Part A Program Guidance
RW Part A 2604(g) 1-2; RW Part A 2604 h 3; 45CFR Part 74.14; 45 CFR Part C 92.25; 2 CFR Part C 215.24; 45 CFR 74.24 and 92.25; 2 CFR Part C 215.24

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Requirement	Indicator	Data Source
Providers will document billing and collection from third party payors, including Medicare and Medicaid, so that payor of last resort requirements are met.	Provider will have established billing and collection policies and procedures.	**Provider's Policies and Procedures** will document the billing and collection procedures.
	Provider will have a consistently implemented billing and collection process and/or electronic system.	**Provider's Billing and Collection System** will document a consistently implemented billing and collection process.
	Provider will have documentation of accounts receivable.	**Provider's Billing and Collection System** will document accounts receivable.
Providers who receive funding in the following service categories […][10] will document participation in Medicaid and certification to receive Medicaid payments, unless waived by the Secretary of Health and Human Services	Document and maintain file information on Medicaid status: • 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	**Provider Files** will document and maintain file information on Medicaid status
Provider must document retention of program income derived from Ryan White-funded services and use of such funds in one or more of the following ways: • Funds added to resources committed to the project or program, and used to further eligible project or program objectives • Funds used to cover program costs	Provider will document billing and collection of program income, and will report program income documented by charges, collections, and adjustment reports or by the application of a revenue allocation formula.	**Provider's Accounting Systems and DOHR Mid-year and Year-end Reports** will document program income by charges, collections, and adjustment reports or by the application of a revenue allocation formula

[10] The categories will need to be identified for CO and added here.

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[*Note:* Program income funds are not subject to the federal limitations on administration (10%), quality management (5%), or core services (75% minimum). For example, all program income can be spent on administration of the Part A program]		

Standard IX Imposition of Participant Charges: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section D.[11]

Requirement	Indicator	Data Source
Providers must document policies and procedures that specify charges to participants for services.	Policies and procedures must document sliding fee discount policy.	**Provider's Policies and Procedures** document a sliding fee discount policy.
	Policies and procedures must document current fee schedule.	**Provider's Policies and Procedures** document a current fee schedule.
	Participant's files/records must document sliding fee eligibility applications.	**Participant's File** includes sliding fee eligibility applications.
	Participant's files/records must document fees charged to and paid by participants.	**Participant's File** documents fees charged to and paid by participants.
	Policies and procedures must document process for charging, obtaining, and documenting participant charges through a medical practice information system, manual or electronic.	**Provider's Policies and Procedures** documents process for charging, obtaining, and documenting participant charges through a medical practice information system, manual or electronic.

[11] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section D; Part A 2605 2 A-B; RW part A 2605 (e) 1 A-B; RW part A 2605 (e) 1 C-E

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Requirement	Indicator	Data Source
Provider's policies and procedures must document that no charges are imposed on participants with incomes below 100% of the Federal Poverty Level (FPL)	Provider's policy and procedures document that the sliding fee discount policy and schedule do not allow participants below 100% of FPL to be charged for services	**Provider's Policies and Procedures** document that the sliding fee discount policy and schedule do not allow participants below 100% of FPL to be charged for services
	Participant files demonstrate that the policy is being consistently followed.	**Participant's Files** demonstrates that the charges are not assessed on participants with incomes below 100% of the FPL.
Provider's policies and procedures must document that charges to participants with incomes greater than 100% of poverty are based on a discounted fee schedule and a sliding fee scale. The policies must cap total annual charges for Ryan White services based on percent of patient's annual income.[12]	Providers must have in place a fee discount policy that caps total annual charges for Ryan White services based on percent of patient's annual income, as follows: • 5% for patients with incomes between 100% and 200% of FPL. • 7% for patients with incomes between 200% and 300% of FPL. • 10% for patients with incomes greater than 300% of FPL .	**Provider's Policies and Procedures** document a fee discount policy that caps total annual charges for Ryan White services based on percent of patient's annual income, as follows: • 5% for patients with incomes between 100% and 200% of FPL. • 7% for patients with incomes between 200% and 300% of FPL. • 10% for patients with incomes greater than 300% of FPL.
	Identify who has responsibility for annually evaluating participants to establish individual fees and caps.	**Provider's Policies and Procedures** identify who has responsibility for annually evaluating participants to establish individual fees and caps.
	Track Part A charges or medical expenses inclusive of enrollment fees, deductible, co-payments, etc.	**Provider's tracking system,** documents all Part A charges or medical expenses inclusive of enrollment fees, deductible, co-payments, etc.

[12] We know from HRSA this applies across all Part A providers, but does it also apply across all RW Parts including ADAP?

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Requirement	Indicator	Data Source
	A process for alerting the billing system that the participant has reached the cap and should not be further charged for the remainder of the year.	**Provider's Policies and Procedures** identify a process for alerting the billing system that the participant has reached the cap and should not be further charged for the remainder of the year.
	Participant files demonstrate that the policy is being consistently followed.	**Participant's File** demonstrates that the policy is being followed and caps total annual charges for Ryan White services based on percent of patient's annual income.

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Standard X Fiscal Management: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Sections E and F.[13]

Requirement	Indicator	Data Source
Provider must comply with all the established standards in the Code of Federal Regulations (CFR) for nonprofit organizations, hospitals, institutions of higher education, and state and local governments.	Provider must comply with all the established standards in the Code of Federal Regulations (CFR) for nonprofit organizations, hospitals, institutions of higher education, and state and local governments. Included are expectations for: • Payments for services • Program income • Revision of budget and program plans • Non-federal audits • Purpose of property standards, including the purpose of insurance coverage, equipment, supplies, and other expendable property • Purpose of procurement standards, including recipient responsibilities, codes of conduct, competition, procurement procedures, cost and price analysis, and procurement records. • Purpose of reports and records, including monitoring and reporting, program performance, financial reports, and retention and access requirements Purpose of termination and enforcement and purpose of closeout procedures	**Provider's Policies and Procedures and Accounting Systems.** Provider must give grantee representative access to: • Accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports of the provider • All financial policies and procedures, including billing and collection policies and purchasing and procurement policies • Accounts payable systems and policies

[13] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Sections E and F; 45 CFR 77; 45 CFR 74; 45 CFR 78; 45 CFR 94; 45 CFR 79; 45 CFR 80; 45 CFR 82; 45 CFR 74.34; 2 CFR 215.34; 45 CFR 92.32 9(a)

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Requirement	Indicator	Data Source
Provider will maintain comprehensive budgets and reports.	Provider will maintain comprehensive budgets and reports with sufficient detail to account for Ryan White funds by service category, administrative costs and 75/25 rule, and to delineate between multiple funding sources and show program income.	**Provider's Policies and Procedures, Reports, and Accounting System.** The following will be reviewed: • Accounting policies and procedures • Ryan White provider budgets • Accounting system used to record expenditures using the specified allocation methodology • Reports generated from the accounting system to determine if the detail and timeliness are sufficient to manage a Ryan White program
Providers must develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source.	Provider must track and report on tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part A funds and having: • A useful life of more than one year, and • An acquisition cost of $5,000 or more per unit (Lower limits may be established, consistent with recipient policies).	**Provider Reports** will document a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source.

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Standard XI Cost Principles: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section G.[14]

Requirement	Indicator	Data Source
Providers must develop and maintain documentation that services are cost based.	Ensure that budgets and expenses conform to federal cost principles.	**Provider Policies and Procedures and Budgets** will conform to federal cost principles.
Provider must have written procedures for determining the reasonableness of costs, the process for allocations, and the policies for allowable costs, in accordance with the provisions of applicable Federal cost principles and the terms and conditions of the award. Costs considered to be reasonable when they do not exceed what would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs	Providers must have in place policies and procedures to determine allowable and reasonable costs.	**Provider's Policy and Procedure** will document procedures to determine allowable and reasonable costs
	Providers must have reasonable methodologies for allocating costs among different funding sources and Ryan White categories.	**Provider's Policy and Procedure** will document methodologies for allocating costs among different funding sources and Ryan White categories. Make available to the grantee very detailed information on the allocation and costing out of expenses for services provided.

[14] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section G: 2 CFR 230 or OMB A-122; 2 CFR Appending A 225 D 1 (51912) or OMB-87; 2 CFR 230: OMB 122 Appendix A to Part 230; 2 CFR A II 225 Appendix A C (2); 2 CFR 220 Appendix A (C) 3 or OMB A-21; 2 CFR 230; OMB 122; *Determining the Unit Cost of Services* (HRSA publication);

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Requirement	Indicator	Data Source
Requirements to be met in determining the unit cost of a service: • Unit cost not to exceed the actual cost of providing the service. • Unit cost to include only expenses that are allowable under Ryan White requirements. • Calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided.	Providers must have in place systems that can provide expenses and participant utilization data in sufficient detail to do the following: • Calculate unit costs based on historical data • Reconcile projected unit costs with actual unit costs on a yearly or quarterly basis.	**Provider's Policy and Procedure** will document systems that can provide expenses and participant utilization data in sufficient detail to calculate unit cost. Providers must have unit cost calculations available for grantee review

Standard XII Auditing Requirements. Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section H.[15]

Requirement	Indicator	Data Source
Recipients and sub-recipients of Ryan White funds that are institutions of higher education or other non-profit organizations (including hospitals) to be subject to the audit requirements contained in the Single Audit Act Amendments of 1996 (31 USC 7501–7507) and revised OMB Circular A-133, with A-133 audits required for all grantees and subgrantees receiving more than $500,000 per year in federal grants.	Provider will: • Conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds). • Request a management letter from the auditor. • Submit the audit and management letter to the grantee. • Prepare and provide auditor with income and expense reports that include payor of last resort verification.	**Provider Documentation** Provider will submit the audit and management letter to the grantee. Any reportable conditions will be addressed in DOHR monitoring recommendations for the Provider through the Recommended Improvement Plan and/or Compliance Plan.

[15] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section H; CFR 74.26; 2 CFR 215/26 A-133 Audit Guidelines; Circular A-133 or Audits for Non-profits

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Requirement	Indicator	Data Source
Selection of auditor to be based on policies and procedures established by the Board of Directors (if nonprofit).	Provider will have financial policies and procedures that guide selection of an auditor.	**Provider's Policies and Procedures** will document the process for selection of an auditor.

Standard XIII Matching or Cost Sharing Funds: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section I.[16]

Requirement	Indicator	Data Source
Providers who provide matching or cost sharing funds must report these funds to DOHR and meet the verification process.	Providers who provide matching or cost sharing funds meet the following verification process: Ensure that non-federal contributions: • Are verifiable in provider records. • Are not used as matching for another federal program. • Are necessary for program objectives and outcomes. • Are allowable. • Are not part of another federal award contribution (unless authorized). • Are part of the approved budget. • Are part of unrecovered indirect cost (if applicable). • Are apportioned in accordance with appropriate federal cost principles. • Include volunteer services, if used, that are an integral and necessary part of the program, with volunteer time allocated value similar to amounts paid for similar work in the provider organization. • Value services of contractors at the employees' regular rate of pay plus reasonable, allowable and	**Provider's Financial Documentation** will include and make available for review: • Annual comprehensive budget. • Documentation of all in-kind and other contributions to Ryan White program. • Documentation of other contributed services or expenses.

[16] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section I; CFR 45 part 74.2 Definitions 45; CFR Part C 92.24 2; CFR 215.27; CFR 74.23

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	allocable fringe benefits. • Assign value to donated supplies that are reasonable and do not exceed the fair market value. • Value donated equipment, buildings, and land differently according to the purpose of the award. • Value donated property in accordance with the usual accounting policies of the recipient (not to exceed fair market value).	

Standard XIV Fiscal Procedures: Providers must have systems in place that meet the requirements outlined in the HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section K. [17]

Requirement	Indicator	Data Source
Provider has policies and procedures for handling revenues from the Ryan White grant, including program income.	Establish policies and procedures for handling Ryan White revenues including program income.	**Provider's Policies and Procedures**, detailed chart of accounts and general ledger will be made available for grantee review upon request.
	Prepare a detailed chart of accounts and general ledger that provide for the tracking of Part A revenue.	**Provider will provide a** detailed chart of accounts and general ledger. These will be made available for grantee review upon request.
Providers will grant access to payroll records, tax records, and invoices with supporting documentation to show that expenses were actually paid appropriately with Ryan White funds.	Maintain file documentation of payroll records and accounts payable, and hard-copy expenditures data.	**Provider's files and documentation** will be made available to grantee upon request.

[17] HIVAIDS Bureau Monitoring Standards for Part A and B Grantees: Part A: Fiscal Monitoring Standards (Draft July 2010)-Section K; A-133 Accounting Standards; 45CFR 74.61 (b)4 (e)
45CFR 92.4; Fair Labor Standards A (29 CFR Part 516);A-122 8 a-m; A-122; 2010 Part A Guidance

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Requirement	Indicator	Data Source
Providers will document employee time and effort, with charges for the salaries and wages of hourly employees.	Maintain payroll records for specified employees. Establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources. This must: • Be supported by documented payrolls approved by the responsible official. • Reflect the distribution of activity of each employee. • Be supported by records indicating the total number of hours worked each day.	**Provider's Payroll records and allocation methodology** will be made available to grantee upon request.
Provider's fiscal staff have responsibility for: • Ensuring adequate reporting, reconciliation, and tracking of program expenditures • Coordinating fiscal activities with program activities (*For example, the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, formula and supplemental unobligated balances, and program income)* • Having an organizational and communications chart for the fiscal department	Providers will maintain: • Program and fiscal staff resumes and job descriptions. • Staffing Plan and grantee budget and budget justification. • Provider's organizational chart.	**Provider's documents and files demonstrate:** • Program and fiscal staff resumes and job descriptions. • Staffing Plan and grantee budget and budget justification. • Provider's organizational chart.

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