Policies/Procedures

Standard II Access to Care:

- ☐ Provider's Procedures demonstrate that 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.
- ☐ Policy demonstrates that when requested or needed, appropriate accommodations is made to meet language or other needs such as illiteracy, visual or hearing impairment.
- ☐ Procedures demonstrate that the provider effectively networks with other service providers, and has established a full range of service referrals.
- ☐ Policies and Procedures will document how provider will comply with the ADA.
- ☐ Policies and Procedures document provider's billing, collection, co-pay and sliding fee policies and demonstrate that they do not act as a barrier to providing services regardless of the participant's ability to pay.
- ☐ Policies and Procedures will document that services are provided regardless of pre-existing conditions.

Standard V Confidentiality

- ☐ 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
- ☐ Policies and Procedures document computer security practices which protect participant confidentiality including a policy that each computer is password protected and staff/volunteers must change passwords every six weeks.

Standard VI Anti-Fraud, Anti-Kickback

- ☐ Policies and Procedures must demonstrate structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally funded program. Including:
  1. Corporate Compliance Plan (Medicare/Medicaid providers only).
  2. Code of Ethics or Standards of Conduct policy
  3. Board bylaws and board policies
- ☐ Policies and Procedures must demonstrate 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. This documentation will include:
  - 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.

- ☐ Policies and Procedures 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. The policy must document how provider discourages soliciting cash or in-kind payments for:
  - Awarding contracts.
  - Referring participants.
  - Purchasing goods or services and/or
  - Submitting fraudulent billings.
- ☐ Policies and Procedures will discourage:
  - The hiring of persons with a criminal record.[1]
  - The hiring of persons being investigated by Medicare or Medicaid.
  - Large signing bonuses.
- ☐ Policies and Procedures, Compliance Plan, and/or Employee Standard of Conduct will differentiate between conduct that merits agency penalties and conduct that represents a possible felony. The policy will:
  - Delineate penalties and disclosure procedures for conduct deemed to be felonies.
  - Include and describe the safe harbors[2] laws.
  - Include the procedure for reporting of non-compliance with the policy.
- ☐ Policies and Procedures, Compliance Plan, and/or Employee standard of Conduct will describe conduct that merits exemption from anti-kickback regulations (safe-harbors).

Standard VIII Income from fee for services

- ☐ Provider's Policies and Procedures document the requirement that Ryan White be the payor of last resort and how that requirement is met.
- ☐ Provider's Policies and Procedures will document billing and collection from third party payors, including Medicare and Medicaid, so that payor of last resort requirements are met.

Standard IX Imposition of Participant Charges

- ☐ Policies and Procedures specify Sliding fee discount policy.
- ☐ Policies and Procedures specify the current fee schedule.
- ☐ Policies and Procedures specify the process for charging, obtaining, and documenting participant charges through a medical practice information system, manual or electronic.
- ☐ Policies and Procedures specify that the sliding fee discount policy and schedule do not allow participants below 100% of FPL to be charged for services.
- ☐ Policies and Procedures specify that the sliding fee discount policy for people earning more than 100% of FPL is based on a percent of the person's annual income (see specific limits in the Standards).
- ☐ Policies and Procedures specify who has responsibility for annually evaluating participants to establish individual fees and caps.

---

[1] The HRSA requirement cites 42 U.S.C. 13207b(b) for this standard. Here is a link, but it doesn't fully support this requirement. Clarification from HRSA required. http://www.law.cornell.edu/uscode/uscode42/usc_sec_42_00001320---a007b.html

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

- ☐ Policies and Procedures specify 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.

Standard XI Cost Principles

- ☐ Provider Policies and Procedures and budgets demonstrate that providers have developed and maintained documentation that services are cost based and ensure that budgets and expenses conform to federal cost principles.
- ☐ Provider's Policy and Procedure will document procedures to determine allowable and reasonable costs.
- ☐ Provider's Policy and Procedure will document methodologies for allocating costs among different funding sources and Ryan White categories.
- ☐ 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 including:
    - Calculate unit costs based on historical data
    - Reconcile projected unit costs with actual unit costs on a yearly or quarterly basis.

Standard XII Auditing Requirements

- ☐ Provider's Policies and Procedures will document the process for selection of an auditor, which are established by the Board of Directors (if nonprofit).

Standard XIV Fiscal Procedures

- ☐ Provider has policies and procedures for handling revenues from the Ryan White grant, including program income, including a detailed chart of accounts and general ledger that provide for the tracking of Part A revenue.
- ☐ Provider will maintain file documentation of payroll records and accounts payable, and hard-copy expenditures data. Documentation will be made available to grantee upon request.
- ☐ Provider's Payroll records and allocation methodology will be made available to grantee upon request. 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 documents and files demonstrate:
  - Program and fiscal staff resumes and job descriptions.
  - Staffing Plan and grantee budget and budget justification.
  - Provider's organizational chart.

Staff/Volunteer File

Standard I Documentation & Eligibility Screening

- ☐ Personnel file of all staff involved in eligibility determination demonstrates that he/she has completed a comprehensive training in eligibility determination requirements.

Standard III Staff and Volunteer Training & Qualification

- ☐ Personnel/Volunteer file contains signed job description.
- ☐ Personnel file contains clinical and/or job performance evaluations for employees who have been with the provider for a year or more.
- ☐ Personnel file has proof of licensure and/or education appropriate for the specific position.
- ☐ Personnel File demonstrates the type, amount (minutes or hours) and date of orientation and training each staff receives both internally and externally. 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 and amount of training each staff received both internally and externally. Every direct care staff receives 20 hours of job specific professional development training annually.
- ☐ Personnel file demonstrates that every staff handling confidential information has received an annual training concerning HIPAA and Confidentiality.
- ☐ Personnel file demonstrates that every staff received annual training on OSHA regulations and Universal Precautions.
- ☐ Personnel or Volunteer file contains background checks.
- ☐ Personnel or Volunteer File contains a copy of a valid driver's license for those staff or volunteers who transport participants.
- ☐ Volunteer file demonstrates the type and amount of orientation the volunteer received. 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.

Standard V Confidentiality:

- ☐ Personnel file has a signed statement by each staff that the staff has read and understood the provider's policies and procedures regarding confidentiality.

- ☐ Personnel file indicates that staff has been trained on any major changes to policies and procedures.

Standard VIII Income from fee for services

- ☐ Personnel file indicates that staff have been trained on Ryan White payor of last resort policies and procedures.

Participant File

Standard I Documentation & Eligibility Screening

- ☐ Participant's file contains confirmation of HIV status. This must be confirmed at initiation of services. 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 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 qualify as low income, less than or equal to 400 percent of Federal Poverty Level.
- ☐ 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.
- ☐ 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.
- ☐ Participant's file and CAREWare data demonstrate that participants receive only allowable services.
- ☐ 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.
- ☐ 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.

Standard V Confidentiality

- ☐ Participant's file contains a signed statement that the participant was informed of their rights confidentiality at intake.
- ☐ Participant's file contains 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.

Standard VIII Income from fee for services

- ☐ Participant's file documents they have been screened for insurance coverage and eligibility for third party programs, and helped to apply for such coverage.

Standard IX Imposition of Participant Charges

- ☐ Participant's File includes sliding fee eligibility applications.
- ☐ Participant's File documents fees charged to and paid by participant.
- ☐ Participant's Files demonstrates that the charges are not assessed on participants with incomes below 100% of the FPL.
- ☐ Participant's File demonstrates that the sliding fee scale policy is being followed and caps total annual charges for Ryan White services based on percent of patient's annual income.

Provider's Files, Reports, Systems

Standard II Access to Care

- ☐ Provider's files will document ADA complaints and grievances, with documentation of complaint review and decision reached.
- ☐ Provider will maintain file of materials documenting Consumer Advisory Board (CAB) membership and meetings, including minutes.
- ☐ Provider's Files demonstrate implementation of satisfaction survey tool, focus groups, and/or public meetings including analysis and use of results.
- ☐ 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.
- ☐ 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.

Standard IV Quality Assurance:

- ☐ Each provider will collect participant level data to support CAREWare reporting and other data reports as indicated.
- ☐ Provider will adopt a quality improvement system (Chronic Care Model or other) to guide work plans and other quality management activities.

Standard VI Anti-Fraud, Anti-Kickback

- ☐ 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.

☐ 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.

Standard VII Limitation on, and Unallowable Uses of Part A Funding

☐ Provider's DOHR Contract Budget provides sufficient detail to identify administrative expenses.

☐ Providers Monthly Invoices to DOHR provide sufficient detail to identify administrative expenses.

☐ Providers DOHR Contract Budget and Monthly Invoices will be tracked in sufficient detail to document that they do not include the identified unallowable costs.

Standard VIII Income from fee for services

☐ 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 Billing and Collection System will document a consistently implemented billing and collection process from third party payors, including Medicare and Medicaid, so that payor of last resort requirements are met.

☐ Provider's Billing and Collection System will document accounts receivable.

☐ Provider Files will 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 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.

Standard IX Imposition of Participant Charges

☐ Provider's tracking system, documents all Part A charges or medical expenses inclusive of enrollment fees, deductible, co-payments, etc.

Standard X Fiscal Management

- ☐ 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 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

- ☐ 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 Reports will 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).

Standard XI Cost Principles

- ☐ Provider Policies and Procedures and budgets demonstrate that providers have developed and maintained documentation that services are cost based and ensure that budgets and expenses conform to federal cost principles.

Standard XII Auditing Requirements

- ☐ 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.

Standard XIII Matching or Cost Sharing Funds

☐ 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 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).

Site Visit Inspection

Standard II Access to Care

☐ 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.

☐ Site visit inspection of agency facility. Provider will ensure that the facility is accessible by public transportation or provide for transportation.

☐ Provider will maintain visible suggestion box or other participant input mechanism.

Standard V Confidentiality

☐ Site visit inspection of agencies facility. Areas in which participant contact occurs allow exchange of confidential information in a private manner

☐ Site Visit observation. Records, hard copy materials maintained under double lock (in locked files and in locked areas) secure from public access.