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Date and Time Activity

November 25, 2014 RFP Released. The RFP is also available online at <http://health.baltimorecity.gov/hiv-std-services/ryan-white-program>

November 25, 2014 BIDDER’S CONFERENCE – Sheppard Pratt

9:30AM – 12:30PM

December 11, 2014 BIDDER’s TELECONFERENCE

 Dial in: 443/984-1696

 Conf. ID: 252378

December 15, 2014 LETTER OF INTENT. Email Letters of Intent to ryan.white@baltimorecity.gov

January 14, 2015 PROPOSALS DUE. Submit proposals to ryan.white@baltimorecity.gov

Due by 3:00 PM No one will be available after 3pm to assist with submission. BCHD will not be responsible for delays in delivery.

January 19-30, 2015 PROPOSAL REVIEW/EVALUATION PERIOD. Proposals will be reviewed by an independent review panel, including consumers and content experts.

February 23, 2015 Notification of Award. Letters will be mailed notifying applicants if their proposal will be funded or not.

Please submit questions specific to this announcement to Sonney Pelham @ Sonney.Pelham@baltimorecity.gov .

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## A. Background

The United States has accomplished many successes in fighting HIV producing a wealth of information about HIV disease, including a number of critical tools and interventions to diagnose, prevent, and treat HIV infection. HIV transmission rates have been dramatically reduced in the United States and people with HIV are living healthier and more productive lives than ever before. Nevertheless, much more needs to be done. With more than one million Americans living with HIV, there are more people in need of testing, prevention, and treatment services than at any point in history, and ongoing research efforts are needed to find a cure for HIV/AIDS and continue to develop improved prevention tools and effective treatments.[[1]](#footnote-1)

The challenges we face are sobering:

* + - Approximately one in five people living with HIV are unaware of their status, placing them at greater risk for spreading the virus to others.[[2]](#footnote-2)
		- Roughly three-fourths of HIV/AIDS cases in the United States are among men, the majority of whom are gay and bisexual men.[[3]](#footnote-3)
		- One-fourth of Americans living with HIV are women, and the disease disproportionately impacts women of color. The HIV diagnosis rate for Black women is more than 19 times the rate for White women.
		- Racial and ethnic minorities are disproportionately represented in the HIV epidemic and die sooner than Whites.
		- The South and Northeast, along with Puerto Rico and the U.S. Virgin Islands, are disproportionately impacted by HIV.
		- One quarter of new HIV infections occur among adolescents and young adults (ages 13 to 29)
		- Twenty-four percent of people living with HIV are 50 or older, and 15 percent of new HIV/AIDS cases occur among people in this age group.

 By focusing our efforts in communities where HIV is concentrated, we can have the biggest impact in lowering all communities’ collective risk of acquiring HIV. [[4]](#footnote-4) To that end the Ryan White Office of the Baltimore City Health Department (BCHD) is seeking health care focused applicants to provide Outpatient Ambulatory Health, Medical Case Management and Primary Care Co-morbidity services to the communities and populations most significantly impacted by HIV/AIDS.

**National HIV/AIDS Strategy (NHAS) Vision**

**The key focus of NHAS is to make “The United States a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.”**

BCHD data indicates that approximately one third of all HIV positive persons in the Baltimore EMA are not in care and may not know their status. Another 25% know their HIV status but have fallen out of care. Applicants should direct their efforts at areas, in the Baltimore EMA, most significantly impacted by HIV/AIDS prevalence.

Under the ACA, uninsured persons are now eligible for medical and behavioral health care benefits that include mental health and substance use services. Patient-centered medical home models are emerging as the standard of care, to ensure comprehensive delivery of care.

Data from Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, and the Centers for Disease Control HIV/AIDS Surveillance Reports indicate that:

* In 2012, an estimated 22.2 million persons (or 8.5% of the population) aged 12 and over were classified with substance abuse or dependence.
* Nearly 21 million of those needing treatment did not receive it.
* Estimated 9.6 million adults aged 18 and older (or 4.1% of all adults) in 2012 had a serious mental illness.
* Approximately 4.1 million of adults in need of mental health services in the past year did not receive them.
* About 25% of people living with HIV in the U.S. are co-infected with viral hepatitis C (HCV), and about 10% are co-infected with viral hepatitis B (HBV).
* About 80% of people with HIV who inject drugs also have HCV.
* An estimated 20% of all new HBV infections are among men having sex with men (MSM), and in the U.S., HCV is twice as prevalent among African Americans as among whites.

Thus sub-grantees must demonstrate knowledge, experience, and capacity to manage the complex care of persons living with HIV/AIDS (PLWHA).

This funding opportunity is intended to establish or expand Outpatient Ambulatory Health, Medical Case Management (MCM) and Primary Care Co-morbidity services.

**I. Application Requirements and Submission**

## Introduction

The Baltimore City Health Department (BCHD) is the Grantee for Ryan White Part A programs. The BCHD Ryan White Office (RWO) identifies sub-grantees through a competitive Request for Proposals (RFP) process to develop and/or expand the systems of care (medical and supportive) to meet the needs of PLWHA who are uninsured or underinsured andresiding in the Baltimore Eligible Metropolitan Area (EMA). The EMA is comprised of Baltimore City and the six counties of Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne’s.

## Contractual Period

The FY 2015 funding cycle is March 1, 2015 through February 29, 2016.

**Eligibility**

To be eligible for Part A funding, applicant organizations must meet the following requirements:

* + Have current 501 ( c ) (3) non-profit status
	+ Be located within the Baltimore EMA (i.e., Baltimore City and the surrounding counties of Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne’s)
	+ Have a documented history of providing medical services to PLWHA.

*Applicants proposing services that qualify for coverage through Maryland Medicaid must have a current Medical Assistance Number or have applied for one by the due date of this application.*

## Application Preparation

Applicants are encouraged to review the guidance and attend or participate on the Bidder’s Meeting/teleconference before deciding to apply. Applicants are encouraged to review the local Standards of Care and the HRSA HAB Performance Measures to assist in preparing a high quality, competitive application. The local Standards of Care can be viewed at [www.baltimorepc.org](http://www.baltimorepc.org/) . HRSA HAB measures are available at http://hab.hrsa.gov/deliverhivaidscare/medicalcasemanagementmeasures.pdf

**Only documentation submitted with the application or received by deadline will be considered.**

**II. DESCRIPTION OF FUNDED SERVICES**

### Outpatient Ambulatory Health Services

FY 2015 available funds: TBD

Outpatient/ambulatory health care includes the provision of professional, diagnostic, and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties).

Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the public health services (PHS) guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Patient-centered medical care provides comprehensive integrated care that is preventative and in many ways self-directed. Patients should be fully involved with their health care decisions and understand that their efforts will be the foundation for stable behavioral health longevity.

Applicant organizations proposing to deliver Outpatient/Ambulatory Medical Care must currently serve and document the provision of medical care to HIV positive patients. Preference will be given to applicants organizations serving at least 100 adult HIV positive patients or 50 pediatric HIV positive patients.

Applicant organizations proposing to deliver Outpatient/Ambulatory Medical Care should retain physicians who satisfy the HIV Medicine Association qualifications criteria, as stated below:

HIV physicians should demonstrate continuous professional development by meeting the following qualifications:

• In the immediately preceding 36 months, provided continuous and direct medical care, or direct supervision of medical care, to a minimum of 25 patients with HIV; AND

• In the immediately preceding 36 months has successfully completed a minimum of 40 hours of Category 1 continuing medical education addressing diagnosis of HIV infection, treatment for HIV disease and co-morbidities, and/or the epidemiology of HIV disease, and earning a minimum of 10 hours per year; AND

• Be board certified or equivalent in one or more medical specialties or subspecialties recognized by the American Board of Medical Specialties or the American Osteopathic Association.

OR,

• In the immediately preceding 12 months, completed recertification in the subspecialty of infectious diseases with self evaluation activities focused on HIV or initial board certification in infectious diseases. In the 36 months immediately following certification, newly certified infectious diseases fellows should be managing a minimum of 25 patients with HIV and earning a minimum of 10 hours of category 1 HIV-related CME per year.

**Purpose**

This RFP aims to identify Outpatient Ambulatory Health Service providers who will provide eligible HIV positive clients with comprehensive medical care. Services must be provided in accordance with clinical practices and HIV-related protocols. Updated guidelines can be found at the AIDSInfo Web site: [Clinical Guidelines for the Treatment of HIV/AIDS](http://aidsinfo.nih.gov/Guidelines/Default.aspx?MenuItem=Guidelines).

## Program Narrative

This section of the proposal provides a description of aspects of the proposed program. It should be succinct, and well organized so that reviewers can understand the proposed program.

## Program Model

1. Provide a narrative statement that confirms understanding and agreement to provide the required services. Describe prior experience and success working with the target population.
2. Indicate the number and type of medical visits to be delivered and the number of clients to be served with Ryan White Part A funding.
3. Describe how HIV medical care will be delivered to the target population.
4. Describe how Ryan White Part A funding will be used in coordination with other funding streams. Describe how the program will ensure Ryan White funds are the payer of last resort.
5. Describe barriers experienced by the target population stemming from Medicaid Expansion and the Affordable Care Act. Describe specific proposed activities to address these challenges.
6. Describe strategies the program uses or will use to identify PLWHA who are unaware of their HIV/AIDS status or lost to care and connect them to medical care.
7. Describe plans to implement a culturally competent patient-centered medical home model.

## Program Administration

1. Describe the process used to separately track Ryan White and MAI funding (if applicable).
2. Include a biographical sketch for key personnel.
3. Provide an organizational chart that illustrates how this program fits into the overall agency.
4. Proposed Subcontractors: State the intention to use subcontractors to perform any portion of the work sought by this RFP. For each such subcontractor, provide the name and address of the subcontractor, a description of the work the subcontractor will perform.

## Data Collection

1. Describe the existing or proposed quality improvement plan.

## Budget

1. Include a budget narrative that is consistent with the scope of work and that clearly explains the funding requested for each line item in the budget.
2. Describe how third party income will be used.

**Review Criteria for Outpatient Ambulatory Health Services**

## Proposal will be reviewed and evaluated by a special team of stakeholders and content experts. Proposals will be reviewed and scored based upon the evaluation criteria below. Individual applications are not compared to other applications; each application is evaluated independently in terms of its responsiveness to application questions.

## Program Model (50 points)

1. Does the proposal demonstrate an understanding of the required services?
2. Does the proposal contain examples of prior experience and success working with the target population?
3. Does the proposal state the number and type of medical visits to be delivered with Ryan White Part A funding?
4. Does the proposal describe how HIV medical care will be delivered to the target population?
5. Does the proposal contain a clear description of how Ryan White Part A funding will be used in coordination with other funding streams?
6. Does the proposal describe how the program will ensure Ryan White funds are the payer of last resort?
7. Does the proposal describe barriers experienced by the target population stemming from Medicaid Expansion and the Affordable Care Act? Are there specific proposed activities to address these challenges?
8. Does the proposal describe strategies the program uses or will use to identify PLWHA who are unaware of their HIV/AIDS status or lost to care and connect them to medical care?
9. Does the proposal describe plans to implement a culturally competent patient-centered medical home model?

## Program Administration (30 points)

1. Does the proposal describe the process used to separately track Ryan White and MAI funding (if applicable)?
2. Does the proposal contain biographical sketch for key personnel?
3. Does the proposal contain an organizational chart that illustrates how this program fits into the overall agency?
4. If applicable, does the proposal clearly state how it will work with subcontractors? Is there a description of the work the subcontractor will perform?

## Data Collection (15 points)

1. Describe the plan for collecting client outcomes by unique record number and the program’s ability to submit data electronically.
2. Describe the existing or proposed quality improvement plan.
3. Describe the plan and methodology to collect data for the Medical Case Management HRSA HAB performance measures (<http://hab.hrsa.gov/deliverhivaidscare/medicalcasemanagementmeasures.pdf>).

## Budget (5 points)

1. Does the application contain a budget and budget narrative?
2. Does the application describe how third party income will be used?

**MEDICAL CASE MANAGEMENT SERVICES**

FY 2015 available funds: TBD

**Purpose**

The purpose of Ryan White Part A Medical Case Management services is to provide a range of services including:

Medical Care Coordination

Social Services Coordination

Benefits Counseling

Treatment Adherence Support

The goal of Medical Case Management is to ensure that persons living with HIV/AIDS (PLWHA) are linked, and retained in primary medical care and adherent to their medication. This funding opportunity is intended to establish or expand Medical Case Management (MCM) services, in the EMA. Programs are expected to have staff with knowledge, skills and ability to provide the range of MCM services.

### Service Category Definition

Medical case management is an approach to routine HIV-related service delivery that is client-centered and community-minded. It is a service that is comprehensive in scope and provides a means to enhance the quality of life for people affected by HIV. It is a system of need and utilization assessment that helps local communities plan and allocate resources while functioning under a specific professional scope of service, ethics, and standards. HIV medical case management assesses the needs of the client, their family and social support system. Medical Case Managers refer, coordinate, monitor, evaluate, and advocate for services to address the clients’ needs. Enhancing client self-care, independence and self-determination are some of the goals of this program. Clients are expected to be involved in all aspects of their care, including problem-solving functions to the maximum extent possible. Proactive, coordinated efforts by case managers in community-based and healthcare settings assist clients in obtaining optimum wellness, as well as making the best use of available resources.

Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Medical Case Managers must possess the following minimum education requirement: a Bachelor’s degree in nursing, social work, psychology, sociology or other related field; or be a Registered Nurse in good standing who is licensed to practice in Maryland. All Medical Case Managers must complete at least 20 hours of continuing education, per year, of which 6 hours must be related to medical issues.

**Medical case management activities include but are not limited to**:

1. Initial assessment of service needs;
2. Development of a comprehensive, individualized service plan;
3. Coordination of services required to implement the plan;
4. Client monitoring to assess the efficacy of the plan;
5. Periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management including face-to-face, phone contact, and other forms of communication.
6. Referrals for medication and/or appointment adherence.

## Program Narrative

This section provides a description of all aspects of the proposed program that must be present within the narrative of the application. It should be succinct, and well organized so that reviewers can understand the proposed program. Use the section headers provided in this RFP when writing the Narrative.

* 1. **Applicant Profile**

## Describe success working with PLWH and collaboration with other community providers/resources including local health departments to link clients to medical services, psychosocial, and other support services.

## Describe access to and ability to communicate with the community to be served.

## Describe the process for timely coordinated access to medical and support services, including the follow-up care of clients.

## Describe the process for optimizing linkage to care.

## Program Model

## The goal of the Medical Case Management is to ensure that persons living with HIV (PLWH) are linked, retained in primary medical care and adherent to their medication.

1. Describe how medical case management collaborates with or intends to collaborate with outreach programs to address the goals of the continuum of care. Describe the process for linking clients identified by outreach programs to care.
2. Describe any referral relationships with key Points of Entry to promote linkage to HIV related services to HIV-positive individuals not in care. Key Points of Entry include emergency rooms, substance abuse programs, detoxification programs, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling, testing and referral sites, mental health programs and homeless shelters.
3. Provide a narrative description of the services to be provided, the composition of the care team, and manner and frequency in which cases will be reviewed.
4. Describe the eligibility identification process used to determine if an individual is eligible for services.
5. Provide a narrative description of the organization’s, identification, intake, psychosocial needs assessment, and care-plan development for each client.
6. Provide a narrative description of existing or proposed collaborative relationships with medical care and integrated behavioral health care providers. List the providers that you have current memorandum of understandings (MOUs) with. If an applicant provides medical care and behavioral health services internally, the applicant must describe how the MCM department communicates with other departments.
7. Describe the referral and follow-up process for clients who are not appropriate for agency case management, but who are in need of services.
8. Describe the target population to be served.
	1. Program Administration
		1. Describe key personnel and their duties for this program, including the data collection personnel. Attach an organizational chart that illustrates how this program fits into the overall agency. Describe the approach to fill vacant staff positions that are essential for delivery, oversight and monitoring of services.
		2. Describe the process for screening and enrolling clients in insurance programs (i.e. Medicare, Medicaid, Marketplace etc.) to ensure that Ryan White funds are the payer of last resort.
		3. Describe the processes and mechanisms to distinguish which clients are served by each Ryan White funding stream to avoid duplication of services.

## Data Collection

* + 1. Describe the plan for collecting client outcomes by unique record number and the program’s ability to submit data electronically.
		2. Describe the existing or proposed quality improvement plan.
		3. Describe the plan and methodology to collect data for the Medical Case Management HRSA HAB performance measures (<http://hab.hrsa.gov/deliverhivaidscare/medicalcasemanagementmeasures.pdf>).

## Budget

## Include a budget narrative that is consistent with the Statement of Work.

## Clearly explain the funding requested for each line item in the budget.

* + 1. Describe how third party income will be used. Third party sources include Medicaid, Medicare, Children’s Health Insurance Programs (CHIP) and private insure including options under the health insurance marketplace.

The budget period is March 1, 2015 to February 29, 2016. Submit adetailed budget narrative and the budget forms included in this RFP, as Attachment A. Budget forms not pertaining to your program should be marked not applicable. **The budget is not scored**.

## Application Review Criteria: Medical Case Management

## Proposal will be reviewed and evaluated by a special team of stakeholders and content experts. Proposals will be reviewed and scored based upon the evaluation criteria below. Individual applications are not compared to other applications; each application is evaluated independently in terms of its responsiveness to application questions.

1. **Applicant Profile** (10 points)

## Does the application describe success in working with PLWH and collaboration with other community providers/resources including local health departments to link clients to medical services, psychosocial, and other support services?

## Does the application describe access to and ability to communicate with the community to be served?

## Does the application describe the process for timely coordinated access to medical and support services, including the follow-up care of clients?

## Does the application describe the process for optimizing retention in care?

## Program Model (50 points)

* + 1. Does the application describe how medical case management collaborates with or intends to collaborate with outreach programs to address the goals of the continuum of care? Does the application describe the process for linking clients identified by outreach programs to care?
		2. Does the application describe any referral relationships with key Points of Entry to promote linkage to HIV related services for HIV-positive individuals not in care?
		3. Does the application provide a narrative description of the services to be provided, the composition of the care team, and manner and frequency in which cases will be reviewed?
		4. Does the application describe the eligibility identification process used to determine if an individual is eligible for services?
		5. Does the application provide a narrative description of the organization’s the baseline-evaluation period phases, identification, intake, psychosocial needs assessment, and care-plan development?
		6. Does the application provide a narrative description of existing or proposed collaborative relationships with medical care and integrated behavioral health care providers? Does the application list the providers with whom it has current memorandum of understandings (MOUs)? Does the application discuss how the MCM department communicates with other departments?
		7. Does the application describe the referral and follow-up process for clients who are not appropriate for agency case management, but who are in need of services?
		8. Does the application describe the target population to be served?
	1. **Program Administration** (30 points)
		1. Does the application describe key personnel for this program, including the data collection personnel? Does the application contain an organizational chart that illustrates how this program fits into the overall agency? Does the application describe the process for filling vacant staff positions that are essential for delivery, oversight and monitoring of services?
		2. Does the application describe the process for screening and enrolling clients in insurance programs (i.e. Medicare, Medicaid, Marketplace etc.) to ensure that Ryan White funds are the payer of last resort?
		3. Does the application describe the processes and mechanisms, to distinguish which clients are served by each Ryan White funding stream to avoid duplication of services?
		4. Does the application describe how third party income will be used? Third party sources include Medicaid, Medicare, Children’s Health Insurance Programs (CHIP) and private insure including options under the health insurance marketplace.

## Data Collection (10 points)

* + 1. Does the application describe the plan for collecting client outcomes by unique record number and the program’s ability to submit data electronically?
		2. Does the application describe the existing or proposed quality improvement plan?
		3. Does the application describe the plan to collect data for the Medical Case Management HRSA HAB performance measures?

## Budget

1. Does the application contain a budget and budget narrative?
2. Does the application describe how third party income will be used?

**Primary Medical Care Co-Morbidity**

Primary medical care-Co-morbidity is the provision of integrated, coordinated care for persons with HIV/AIDS, co-morbid conditions, and difficulty adhering to medical appointments and medications.

This service category is intended to address barriers that hinder retention in care. Providers must have or propose systems that provide comprehensive services to ensure that all obstacles to care are considered in the development of a plan.

PMC Co-morbidity programs must have a Care Coordinator. Care Coordinators must have a Bachelor’s degree in nursing, social work or be a Registered Nurse in good standing. Each client must be assigned to a single care coordinator.

## Program Narrative

This section provides a description of all aspects of the proposed program that must be present within the narrative of the application. It should be succinct, and well organized so that reviewers can understand the proposed program. Use the section headers provided in this RFP when writing the Narrative.

1. Applicant Profile

## Describe the services your organization provides to PLWHA

## Describe your program’s success and/or innovative strategies for working with PLWH with adherence issues.

##

## Program Model

## The goal of the PMC Co-morbidity is to improve retention in care for PLWHA who need assistance with adherence.

## Describe the proposed model of care.

1. Describe how PMC Co-morbidity will differ from Medical Case Management services.
2. Describe the process for recruiting clients and the strategies that will be used for engaging and retaining clients in care.
3. Describe the role of the Care Coordinator and how that individual will interact with other programs or departments
4. Describe the composition of the proposed care team and the process for providing services to persons with adherence issues.
5. Describe the referral and follow-up process.
6. Describe the criteria that will be used to terminate services to clients.
7. Discuss goals and objectives for this category.
8. Program Administration
9. Describe key personnel, roles and responsibilities as it pertains to this program.
10. Describe the approach to fill vacant staff positions that are essential for delivery, oversight and monitoring of services.
11. Attach an organizational chart that illustrates how this program fits into the overall agency.

## Data Collection

1. Describe performance measures that will be monitored to determine the effectiveness of the program.
2. Describe the existing or proposed quality improvement plan.

## Budget

## Include a budget narrative that is consistent with the Statement of Work.

## Clearly explain the funding requested for each line item in the budget.

***Review Criteria for PMC Co-morbidity***

## Proposal will be reviewed and evaluated by a special team of stakeholders and content experts. Proposals will be reviewed and scored based upon the evaluation criteria below. Individual applications are not compared to other applications; each application is evaluated independently in terms of its responsiveness to application questions.

1. Applicant Profile(10 points)

## Does the proposal contain a clear description of services offered?

## Does the proposal outline prior successes or innovative plan for addressing noncompliance?

##

## Program Model (50 points)

## Does the proposal have a clear program model?

1. Does the proposal distinguish between PMC Co-morbidity and Medical Case Management services?
2. Does the proposal discuss a recruitment process and strategies for engaging and retaining clients in care?
3. Does the proposal describe the role of the Care Coordinator and how that individual will interact with other programs or departments?
4. Does the proposal describe the composition of the proposed care team and how team members interact with each other?
5. Does the proposal contain a clear referral and follow-up process?
6. Does the proposal discuss the criteria for terminating services to clients?
7. Does the proposal contain clear goals, objectives, and activities for this category?
8. Program Administration(30 points)
9. Does the proposal describe key personnel, roles and responsibilities as it pertains to this program?
10. Does the proposal describe the process for filling vacant staff positions?
11. Does the proposal contain an organizational chart that illustrates how this program fits into the overall agency?

## Data Collection (10 points)

1. Does the proposal have clear performance measures that will be monitored to determine the effectiveness of the program?
2. Does the proposal describe the existing or proposed quality improvement plan?

## III. Required Attachments

Attachments should be submitted with the following enumeration: (Items in bold require forms which are attached)

1. Budget Package
2. Biographical Sketches, Position Descriptions, Organizational Chart
3. Professional Licenses and Certifications
4. Memoranda of Understanding (if applicable)
5. Work Plan(s)
6. The Contract Information & Verification Form
7. Consumer Advisory Board Member List
8. Assurances
9. Agency Quality Assurance Plan
10. Liability Insurance Verification

## Application Format Requirements

**Application Page Limit and Numbering**

Applications may not exceed 30 pages when printed.The 30-page limit includes the abstract, program narrative and budget narrative. Attachments and letters of commitment and/or support are not included in the page limit. **Applications that exceed these limits will be deemed non-responsive to the RFP.**

## Font

## Use Arial, Calibri, or Times Roman. The narrative portions of the application must be submitted in 12 point fonts, single line spacing and pages numbered chronologically. Do not use colored, oversized, or folded materials. Charts, graphs, footnotes, and budget tables use 10 point font, must be legible. When scanned or reproduced, the charts must still be clear and legible. Do not include organizational brochures or other promotional materials, slides, films, clips, etc.

## Paper Size and Margins

## The application must be written on 8 ½” x 11” white paper. Margins must be at least one (1) inch at the top, bottom, left, and right of the paper. Left-align text.

## Organization Name

## The applicant’s name and service category must appear in the footer of the application.

## Allowable Attachment or Document Types

## BCHD will only accept the following types of attachments:

 Microsoft Word

Adobe Portable Document Format

Microsoft Excel

Files with unrecognizable extensions will not be accepted and will not be considered as part of the application.

1. **Conditions of Award**

**Federal FUNDING REQUIREMENTS**

1. **Quality Management:**

Services supported by Part A funds will be assessed according to the HRSA HAB performance measures for clinical services. These measures are available for review at <http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html>. This assessment may be conducted via site visits including chart abstraction, client level data submissions or a combination of the two.

Specific performance measures are required for each service category.

Sub-grantees falling more than 5% below the EMA targets will be required to submit a quality improvement plan including data submissions showing progress toward the target until the target performance rate is achieved. Programs that are above all thresholds can opt to focus on any other HRSA HAB measure needing improvement or another measure of interest.

The following tables define the performance measure and how the measure is calculated.

**Table 1 OAHS Clinical Performance Measures**

|  |  |  |  |
| --- | --- | --- | --- |
| Measure | Numerator | Denominator | Baltimore EMA Target |
| Prescription of HIV Antiretroviral Therapy | Number of patients from the denominator prescribed HIV antiretroviral therapy1 duringthe measurement year | Number of patients, regardless of age, with a diagnosis of HIV with at least one medicalvisit in the measurement year | 91% |
| Viral Load Suppression – the % of clients with a viral load less than 200 copies at the last test in the 12 month measurement period | The number of patients in the denominator with a viral load less than 200 copies at the last viral load test in the 12 month measurement period | The number of clients with at least one medical visit in the 12 month measurement period | 85%\* |
| Pneumocystis jiroveci Pneumonia (PCP) Prophylaxis | **Numerator 1**: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP)prophylaxis within 3 months of CD4 count below 200 cells/mm3**Numerator 2**: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP)prophylaxis within 3 months of CD4 count below 500 cells/mm3 or a CD4 percentagebelow 15%**Numerator 3**: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP)prophylaxis at the time of HIV diagnosis**Aggregate numerator**: The sum of the three numerators | **Denominator 1**. All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4count below 200 cells/mm3, who had at least two visits during the measurement year,with at least 90 days in between each visit; and,**Denominator 2**. All patients aged 1 through 5 years of age with a diagnosis of HIV/AIDSand a CD4 count below 500 cells/mm3 or a CD4 percentage below 15%, who had at leasttwo visits during the measurement year, with at least 90 days in between each visit; and,**Denominator 3**. All patients aged 6 weeks through 12 months with a diagnosis of HIV, whohad at least two visits during the measurement year, with at least 90 days in between eachvisit**Total denominator:** The sum of the three denominators | 87% |

\*set by the Maryland Regional Group ^Top 25% performance rate from the in+ Care Campaign

**Table 2 MCM Clinical Performance Measures**

|  |  |  |  |
| --- | --- | --- | --- |
| Measure | Numerator | Denominator | Baltimore EMA Target |
| Care Plan | The number of patients in the denominator with a care plan developed or updated twice a year at least 3 months apart and in the measurement period. | The numbers of clients with at least 1 MCM visit in the 12 month measurement period. | 85%\* |
| Linkage to HIV Medical Care (medical visit frequency) | The number of clients in the denominator who active in MCM and had at least one medical visit in each 6 month period of the 24 month measurement period with at least 60 days between medical visits as a result of referral in the measurement period | The number of clients with at least one medical visit in the first 6 months of the 24 month measurement period | 90%^ |

**Table 3 PMC Co-morbidity Clinical Performance Measures**

|  |  |  |  |
| --- | --- | --- | --- |
| Measure | Numerator | Denominator | Baltimore EMA Target |
| Retention in care – the % of clients with at least 1 medical visit in each 6 month period of the 24 month measurement period with at least 60 days between medical visits | The number of clients in the denominator who had at least one medical visit in each 6 month period of the 24 month measurement period with at least 60 days between medical visits | The number of clients with at least one medical visit in the first 6 months of the 24 month measurement period | 90%^ |
| Gap in Medical Visits | Number of patients in the denominator who did not have a medical visit in the last 6months of the measurement year | Number of patients, regardless of age, with a diagnosis of HIV who had at least onemedical visit in the first 6 months of the measurement year | 14%^ |
| Viral Load Suppression – the % of clients with a viral load less than 200 copies at the last test in the 12 month measurement period | The number of patients in the denominator with a viral load less than 200 copies at the last viral load test in the 12 month measurement period | The number of clients with at least one medical visit in the 12 month measurement period | 85%\* |

^in+Care Campaign \* Maryland Regional Group

1. Sub-grantees awarded Ryan White funds must comply with Federal grant requirements pursuant to the law and program guidelines of the Ryan White CARE Act. Part A funds are to be used in a manner consistent with current and future program policies as developed by the Division of Service Systems, HIV/AIDS Bureau, the Health Resources and Services Administration (HRSA). These policies are available on the HAB website: [www.hab.hrsa.gov.](http://www.hab.hrsa.gov/)
2. Sub-grantees must document referral relationships with key Points of Entry that detail linkages to promote access to HIV related services to HIV-positive individuals not in care. Examples of Key Points of Entry are emergency rooms, substance abuse programs, detoxification programs, adult and juvenile detention facilities, sexually transmitted disease clinics, federally qualified health centers, HIV counseling, testing and referral sites, mental health programs and homeless shelters. This must be accomplished through the development of Memoranda of Understandings.
3. Sub-grantees must establish a mechanism to ensure that referrals occur at the client level for health or support services outside of the grant agency.
4. Grant funds may not be used to supplant or replace current state or local funding. HRSA requires that documentation of the spending of dollars must be maintained and clear. This requirement is subject to audit.
5. Under Section 2605 (a)(6) Part A funds cannot be used to pay for any item or service that can reasonably be expected to be paid under any other State compensation program, insurance policy, or any other Federal or State health benefits program or by any entity that provides health services on a prepaid basis. This means that sub-grantees are expected to make reasonable efforts to secure other funding instead of Ryan White CARE Act funds whenever possible.
6. If sub-grantees elect to use Ryan White CARE Act funds for client services, that are eligible for both third party reimbursement and grant funding, the sub-grantees must have a system in place to bill and collect from the third party payer. Only if the client has been determined to not be eligible for reimbursement from Medicaid or other third party payers, may the grantee use grant funds to provide these services. The sub-grantees may use Ryan White CARE Act funds while a Medicaid eligibility determination is pending, but must back bill Medicaid during the retroactive period of enrollment. The Fiscal Agent (*Associated Black Charities*) (ABC) reserves the right to audit records and or require proof that grant funds are not being used to support clients enrolled in third party reimbursement programs. Under Section 2604 (e), ABC can only contract with Medicaid certified sub-grantees if the service is covered under Medicaid.
7. Services supported by Part A funds must be offered without regard to the individual’s ability to pay or the individual’s past or present health condition, but must be offered in a setting that is accessible to low income persons living with HIV disease. The Baltimore City Health Department (BCHD), as the Grantee, has established eligibility requirements as follows: a) lab slip documenting the HIV-positive status and/or medical diagnosis as evinced by the signature of a physician; b) residency in the Baltimore EMA; c) income at 300% of the Federal poverty level or below; d) assessment of third party payer capacity; and e) use of the Eligibility Verification System (EVS) of the State of Maryland. Agencies are expected to establish and monitor procedures to verify and document client eligibility.

**Sub-grantee Requirements**

1. Per Presidential Executive Order issued August 11, 2000, every Ryan White program that receives federal funds is required to take reasonable steps to assure meaningful access to their programs by Limited English Proficiency (LEP) persons*.* Each covered entity that provides services or benefits directly to the public must develop language assistance procedures for a) assessing the language needs of the population served; b) translating both oral and written materials.
2. Ryan White Part A sub-grantees must ensure that administrative costs do not exceed 10% of the total award. Administrative costs include: depreciation, use allowances on buildings and equipment, costs of operating and maintaining facilities, general administrative expenses associated with executive offices, personnel administration, accounting, costs associated with the management and oversight of program, quality assurance, and other related activities and ‘overhead’ costs. Examples of administrative costs include: rent, utilities, telecommunications (unless directly related to the provision of service), liability and professional insurance, office supplies, audits, computer hardware/software, payroll/accounting services, data collection activities related to the Ryan White HIV/AIDS Program Data Report (RDR), and the Ryan White HIV/AIDS Program Services Report (RSR).
3. The indirect cost rate for all sub-grantees is 10%.

**PERSONNEL REQUIREMENTS**

1. Per instructions in the budget package, the sub-grantees must provide to the BCHD Program Officers, within **30** days of hiring or assignment, the names, job titles, resume and applicable certificates, salaries and percentage of full time equivalency of all personnel funded by this award and hired during this funding period.
2. The sub-grantees(s) must obtain written approval from BCHD before effecting changes regarding key positions funded under this award. Requests for changes in personnel must include a job description, a work plan detailing assignments and time line, the position classification, and information on FTE equivalency.
3. All staff that implements HIV-funded programs must be trained and educated in HIV knowledge and skills relevant to the funded project and attend periodic departmental trainings as required.
4. Criminal Background investigation records must be obtained on all employees and volunteers who work with youth under the age 18, pursuant to Sec. 5-560 through 5-568 of the Family Law Article of the Annotated Code of Maryland.
5. Applicants must present a staffing plan for the proposed service program and provide a justification for the plan that includes education and experience qualifications and rationale regarding the amount of time being requested for each staff position.

Position descriptions must include the roles, responsibilities, and qualifications of proposed project staff, submit as **Attachment B.**  Attachment B should also include biographical sketches for key personnel associated with this project. The staffing plan should include the proposed number of full-time equivalents (FTEs), credentialing, and vacancies.

**PROGRAM REQUIREMENTS**

1. Sub-grantees are required to submit monthly fiscal reports, program reports, work plan updates and other data reports to BCHD. The monthly fiscal reports are due on the 10th of each month. No payment will be made to the sub-grantees if programmatic and fiscal reports have not been received. Patterns of late reporting will be a major factor in future award conditions.
2. **In meeting the Federal requirements under Section 2604 (4) (A), sub-grantees are required to provide data on the number of women, infants, children, and youth. Sub-grantees must submit monthly reports detailing the number of women, infants, youth, and children served under each category. The age parameters for this report are as follows: females aged 25 and older, infants from birth though 24 months, children 2 through 12 years of age and youth 13- 24.**
3. Sub-grantees must submit an unduplicated client-level report and any other required data to BCHD as outlined in the Schedule of Deliverables.
4. The sub-grantees must ensure that communicable disease reporting requirements have been met for all patients served by this grant, specifically reporting by name those with AIDS or symptomatic HIV disease and complying with applicable Department of Health and Mental Hygiene regulations.
5. Organizations providing Primary Medical Care, Primary Medical Care-Co-morbidity or Medical Case Management must submit current licenses and or certificates for programs/staff.

**BUDGET REQUIREMENTS**

The budget period is March 1, 2015 to February 29, 2016. Submit adetailed budget narrative and the budget forms included in this RFP, as Attachment A. Budget forms not pertaining to your program should be marked not applicable. **The budget is not scored**.

**Personnel Costs:** Personnel costs (salaries and wages) should be explained by listing management staff and all other full time equivalents (FTEs) who will be supported. State the position title, percent full time equivalency, annual salary, and the exact amount requested for each person.

**Fringe Benefits:** List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement.

**Administrative/Indirect Costs:** Up to **10%** of the budget can be allocated to administrative costs. Administrative costs are costs incurred for common objectives that benefit multiple programs of the applicant organization, or the organization as a whole, and as such are not readily assignable to a particular funding stream. Staff activities that are administrative in nature must be allocated to administrative costs.

The following are examples of administrative costs:

* Indirect costs rate approved by a national agency does not apply to this **announcement,** the limit for all indirect cost applicable to this announcement is 10 percent of the total cost of the grant.
	+ - Rent, utilities and other facility support costs
		- Personnel costs and fringe benefits of staff members responsible for the management of the project such as the Project Director
		- Telecommunications, including telephone, fax, pager
		- Postage
		- Liability insurance
		- Office supplies
		- Audits
		- Payroll/accounting services
		- Computer hardware/software
		- Data collection activities related to data collection requirements, including the Ryan White legislation Data Report (RDR; formerly CADR), unduplicated Part A client-level data, outcomes and other reports.

**Equipment:** List equipment type and costs. Explain how the items are needed to carry out the program’s goals. Justification and status of current equipment is required when requesting funds for computers and furniture items.

**Supplies:** Separate office supplies from medical and educational (e.g., continuing medical education) purchases. Office supplies may include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes.

**Travel:** List travel costs according to local and long distance travel. For local travel, estimate the mileage rate, number of miles, reason for travel, and staff member/consumers completing the travel. Any travel cost line item must be detailed in the budget justification, and must include the persons traveling and the purpose of the trip. International travel is not permitted.

**Subcontract:** Provide a clear explanation as to the purpose of each sub-contract, how the costs were estimated, and the contract deliverables. Sub-grantees that subcontract any portion of their award must submit a detailed budget form for the percentage of the award that is subcontracted out. The sub-grantee is still responsible for all programmatic and fiscal reports.

**Training:** Any training cost line item must be detailed in the budget justification, and include the name of the individual(s) and the purpose of the training. Training required maintaining licensure is not allowable.

**Other:** Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category.

The sub-grantees are responsible for any funding shortfall that is a result of an overestimation in fee collections.

New sub-grantees must submit Articles of Incorporation as registered with the Maryland Department of Taxation and Assessments, Federal Tax ID Number and proof of 501©(3) status. Sub-grantees must submit documentation of proof of their professional and general liability insurance coverage (**$3,000,000**) and their fidelity bond purchase equal to **33%** of the total award amount.

**Required Meetings:**

Sub-grantees must attend program, fiscal and quality management meetings/trainings.

**Monitoring Roles and Responsibilities:**

Sub-grantees must participate in the site visits which may include (a) CQM chart audits; (b) annual client satisfaction surveys; and (c) meetings. BCHD and ABC will conduct comprehensive site visits, which will include, but not be limited to: interviews of staff, review of fiscal and clinical records, interviews with clients, and observation of service delivery.

Sub-grantees must adhere to all policies and procedures in the local Standards of Care as developed by the Greater Baltimore HIV Health Services Planning Council. It is the responsibility of the sub-grantees to keep the manual current. If requirements change, the sub-grantees are required to meet the new requirements. A copy of the current local Standards of Care is available on the Web: [http://www.baltimorepc.org.](http://www.baltimorepc.org/)

# Funding Exclusions and Restrictions

Pursuant to Section 2605 (a)(6) of the Ryan White legislation, funds cannot be used to pay for any item or service that can reasonably be expected to be paid under any State compensation program, insurance policy, Federal or State health benefits program, or by any entity that provides health services on a prepaid basis. The Ryan White Part A Program is the “payer of last resort.” This means sub-grantees must make reasonable efforts to identify and secure other funding sources outside of Ryan White legislation funds, whenever possible.

If sub-grantees elect to use Ryan White funds for client services that are eligible for third-party reimbursement, the sub-grantees must have a system in place to bill and collect from the third party payer. Ryan White funds are to be used only if a client’s services are not eligible for reimbursement from Medicaid or from other third parties.

Ryan White funds may be used in cases of pending Medicaid eligibility determination but agencies must back bill Medicaid during their retroactive period of enrollment.

 The Ryan White Office reserves the right to audit records and require proof that grant funds are not being used to support clients enrolled in third-party reimbursement programs.

**Part A funds may not be used to supplant current state or local HIV related funding.**

Indirect Costs cannot exceed 10% of the grant award.

### Disallowances

Funds provided through Ryan White contracts may not be used for the following:

* + To make cash payments to intended recipients (*clients*)of services
	+ For the acquisition of real property, building construction, alterations, renovations, or other capital improvements
	+ To supplant other government or private funding for services already in place
	+ Support the costs of operating clinical trials of investigational agents or treatments
	+ Cover the costs of funeral, burial, cremation or other related expenses
	+ Purchase clothing
	+ Make payments directly to recipients of service
	+ Support legal services for criminal defense
	+ Provide direct maintenance expenses of privately-owned vehicles or any other costs associated with a vehicle, such as lease or loan payments, vehicle insurance, or license registration fees
	+ Purchase or improve land, or to purchase, construct, or make permanent improvement to any building, except for minor remodeling
	+ Pay property taxes
	+ Entertainment costs - this includes the cost of amusements, social activities and related incidental costs;
	+ Fundraising expenses
	+ Lobbying expenses and
	+ International travel

Other non-allowable costs can be found in the appropriate OMB Circular, available at [http://www.whitehouse.gov/omb/circulars/.](http://www.whitehouse.gov/omb/circulars/)

### Program Income

The Ryan White HIV/AIDS Program legislation requires grantees to collect and report information on program income. The program income is to be returned to the respective Ryan White HIV/AIDS Program and used to provide eligible services to eligible clients.

As specified on the Part A notice of grant award (NGA), program income must be “Added to funds committed to the project or program and used to further eligible project or program objectives.” Grantees are responsible for ensuring that sub-grantees have systems in place to account for program income, and for monitoring to ensure that sub-grantees are tracking and using program income consistent with grant requirements. Programincome must be reported monthly as a part of the request for payment process.

Sub-grantees must bill in accordance with Federal guidelines and show as grant income all third party reimbursements or fees collected in connection with this project, regardless of the location of service provision or the residence of the client/recipient within the Baltimore EMA.

Fee collections from third party payers and/or self-paying clients are to be projected in the budget submitted to ABC. Actual fee collections will be shown on the final budget reconciliation (B-3 Forms).

## Selection Criteria:

1. Independent Review Panel’s Scores
2. Prior performance
3. Funding utilization
4. Program model
5. Findings from prior site visits or Clinical Quality Management reviews
6. Geographic location
7. Fiscal stability
1. National HIV/AIDS Strategy [↑](#footnote-ref-1)
2. CDC. *Estimates of new HIV infections in the United States.* August 2008. Available at [www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/incidence.pdf](http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/incidence.pdf) [↑](#footnote-ref-2)
3. CDC. *HIV/AIDS Surveillance Report.* 2007; 19: 7. Available at <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/pdf/2007SurveillanceReport.pdf> [↑](#footnote-ref-3)
4. National HIVAIDS Strategy [↑](#footnote-ref-4)