

Ryan White Part A

PLANNING COUNCIL PRIMER



TABLE OF CONTENTS

THE RYAN WHITE HIV/AIDS PROGRAM	1
HOW PART A WORKS	5
PLANNING COUNCIL DUTIES	8
CEO AND GRANTEE DUTIES	15

This publication was funded by the Health Resources and Services Administration, HIV/AIDS Bureau, under contract #213-00-0112 with BETAH, Inc. and John Snow, Inc. and under contract #231-01-0041 with WordPortfolio, Inc. This update was prepared by Mosaica, HRSA/HAB, and Wordportfolio, Inc.

THE RYAN WHITE HIV/AIDS PROGRAM

This primer explains what the Ryan White HIV/AIDS program does. It also describes what planning councils do in helping make decisions about Ryan White HIV/AIDS services to fund and deliver in their geographic areas.

The Ryan White HIV/AIDS Program (previously known as the Ryan White CARE Act) is a Federal program that funds services for people living with HIV/AIDS (PLWHA). Ryan White services are for those who cannot pay for the care they need. Ryan White helps cities, States, and other areas pay for the costs of HIV/AIDS care. It pays for care that is not covered by other programs like Medicaid and Medicare.

The Ryan White legislation is called the Ryan White Treatment Modernization Act of 2006. The legislation was first passed in 1990 as the Ryan White CARE Act. The 2006 law is the third time that Ryan White programs have been reauthorized as Federal legislation since its initial enactment. The legislation spells out who is eligible for services and describes how the money can be used. Most Ryan White funds go to pay for medical and support services for PLWHA and their families. One goal is to get PLWHA into care early and help them stay there and remain healthy.

Most Ryan White funds are grants awarded to local and State areas to address the needs of PLWHA. Many decisions about how to use the money are made by local planning councils and State planning groups, who work as partners with their governments.

The Federal government agency that works with local and State areas that receive the grants is the HIV/AIDS Bureau (HAB), which is part of HRSA, the Health Resources and Services Administration (HRSA). HRSA is part of an even larger agency, the U.S. Department of Health and Human Services (HHS).

Ryan White legislation awards grants under the five sections of the Act: Part A, Part B, Part C, Part D, and Part F (formerly Title I, Title II, Title III, Title IV, and Part F). Below is a short

Ryan White HIV/AIDS Program Funding Categories

- Part A: Local areas hardest hit by the epidemic
- Part B: States, including AIDS Drug Assistance Programs (ADAP)
- Part C: Community early intervention services
- Part D: Services for children, youth, women with HIV disease and their families
- Part F: Includes Special Programs of National Significance (SPNS) models of care, AIDS Education and Training Centers (AETC) training for health care providers, HIV/AIDS Dental Reimbursement Program (DRP) for agencies to reimburse the uncompensated costs incurred by agencies in providing oral health treatment to PLWHA, Community Based Dental Partnership Program (CBDPP) to provide oral health care in the community and train dental professionals; and the Minority AIDS Initiative (MAI) to reduce racial/ethnic disparities in service access and outcomes.

description of each. In most cases, agencies compete for funding by submitting applications to HRSA. Part of the funds that go to Part A and Part B are funded under a formula that relates to the number of living HIV and AIDS cases in these areas.

Part A: Emergency Relief to Local Areas

Part A funds go to local areas that have been hit hardest by the HIV epidemic. These areas are called eligible metropolitan areas (EMAs) or transitional grant areas (TGAs):

- EMAs are metropolitan areas with at least 2,000 new cases of AIDS reported in the past five years and at least 3,000 cumulative living cases of AIDS as of the most recent calendar year. There are 22 EMAs.
- TGAs are metropolitan areas with between 1,000 and 1,999 new cases of AIDS reported in the past five years and at least 1,500 cumulative living cases of AIDS as of the most recent calendar year. There are 34 TGAs

Part A money goes to the chief elected official (CEO) of the major city or county government in the EMA or TGA. (The CEO is usually the mayor. Sometimes it is the county executive, chair of the board of supervisors, or judge.) The CEO is legally the grantee, but usually chooses a department or other entity to manage the grant. That entity is called the grantee. It manages the grant by making sure the funds are used correctly. The grantee works with the Part A planning council in making decisions about how to use the funds.

Part A funds may be used for HIV primary medical care and other medical-related and support services (like medical transportation) that are needed by PLWHA in order to stay in care and achieve quality medical outcomes. A limited amount of the money can be used for planning, managing, and evaluating programs, and for supporting the work of the planning council.

Part B: Support to States

Part B is for States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and the U.S. Pacific Territories and Associated Jurisdictions. Like Part A funds, Part B funds can be used for medical and support services. A major priority is providing medications for people with HIV and AIDS. The Ryan White legislation gives States flexibility to deliver these services under these programs:

- AIDS Drug Assistance Program (ADAP) medications to treat HIV disease
- Health insurance coverage
- Services provided through consortia (groups of providers and community members that plan and deliver care)
- Direct services provided or contracted by the State.

In the past, home and community based care was a separate Part B program area but is now categorized as a “core medical service” that can be funded under Part A, B, or C.

The State decides how to spend this money. States are required to conduct a needs assessment (to determine needs of PLWHA). Based upon needs assessment results, States must set priorities and allocate resources to meet needs. States must also write a comprehensive plan, which is a guide on how to meet those needs.

Many States get input from Part B planning groups. Some are statewide groups. Others cover local areas (like several counties) and are called Part B consortia. They operate much like Part A planning councils, which are described later in this Primer. They are required to assess needed services and make decisions about how to use funds. Some consortia also deliver medical and support services.

Some states also receive Emerging Communities grants. These grants are used to establish and support systems of care in metropolitan areas that are not eligible for Part A funding but have a growing rate of HIV and AIDS. To be eligible for Emerging Communities funds, a metro area must have between 500 and 999 AIDS cases reported in the past five years. To stay eligible, it must have at least 750 cumulative living AIDS cases as of the most recent calendar year.

Part C: Community-Based Early Intervention Services

Part C funds individual agencies, like local public, private non-profit, and hospital-based health clinics. Unlike Part A and Part B, these funds are awarded competitively and go directly to community agencies. While Part C funds many locations around the nation, a funding priority under the legislation is for rural areas and locations that lack HIV-related health services.

Most Part C grants are for programs that provide primary HIV medical care and support services. Part C grantees must provide specific Early Intervention Services (EIS), which include HIV counseling and testing; medical care including medications, other clinical, and diagnostic services; and referrals. They must use at least 50% of the grant for those services, excluding HIV counseling. Part C grantees can use no more than 10% of their grants for administration, including indirect costs. In addition, Part C grantees must use at least 75% of their grant funds for core medical services, the same requirement that applies to Parts A and B, after funds are reserved for clinical quality management and administration.

Part C also funds Capacity Development grants, which are used to help agencies improve their operations so that they can deliver EIS. Part C Planning grants are used to help agencies prepare to become EIS programs.

Part D: Services and Access to Research for Women, Infants, Children, Youth, and Families

Part D funds go directly to local health care organizations or hospitals. The funds are used to provide HIV-related medical and support services to women, infants, children, and youth, and to link them to additional services available in the community. Part D also lets clients know about clinical research trials and helps them learn how to participate if they wish. Part D grantees can use no more than 10% of their grants for administration, not including indirect costs.

Part F: SPNS, AETC, Dental, MAI

Part F funds support five programs.

- **Special Projects of National Significance (SPNS):** SPNS funds go to organizations that are creating new and better ways of serving people living with HIV/AIDS.
- **AIDS Education and Training Centers (AETCs):** AETC funds go to regional and national centers that educate doctors, nurses, dentists, and other health professionals about HIV disease and current treatments.
- **HIV/AIDS Dental Reimbursement Program:** These funds go to dental schools and other dental programs to help pay for dental care for people living with HIV.
- **Community Based Dental Partnership Program:** These funds are to deliver community-based oral health care services for HIV-positive individuals while providing education and clinical training for dental care providers, especially those located in community-based settings.
- **Minority AIDS Initiative:** Part A and Part B programs can apply for MAI funds to address disparities in access, treatment, care, and health outcomes for racial and ethnic minorities. Although MAI is funded separately, Part A and Part B grantees that receive MAI funds are to administer MAI activities as an integral part of their larger Part A and Part B programs.

HOW PART A WORKS

The rest of this Primer describes the people who participate in Part A and what they do.

PARTICIPANTS

Participants in the Part A grant include the following:

- The CEO, who receives the funds on behalf of the EMA or TGA.
- The grantees, the entity chosen by the CEO to manage the grant and make sure funds are used fairly and appropriately.
- The planning council, which conducts planning, decides how to use funds, and works to ensure a system of care that effectively serves all eligible people living with HIV/AIDS in the EMA or TGA.
- HAB/DSS, the Federal government entity within HRSA that makes sure the Ryan White Part A program is implemented correctly.

The Part A Award Process

Each year Congress approves different amounts of funds for Ryan White programs, including Part A. The money for Part A is divided into formula and supplemental funds. Minority AIDS Initiative (MAI) funds are awarded separately.

Formula funds are awarded to EMAs or TGAs based on the number of persons living with HIV and AIDS in the EMA or TGA. Supplemental funds are awarded to the EMA or TGA based on demonstrated need and other factors. EMAs or TGAs must submit a grant application to HAB/DSS each year to receive formula and supplemental Part A funds.

MAI funds are awarded competitively based on a separate application.

The grantee should prepare all Part A applications with planning council input.

The Chief Elected Official (CEO)

The CEO is the person who officially receives the Ryan White Part A funds. The CEO is the Chief Elected Official who is in charge of the major city or county in the EMA or TGA, such as a mayor, chair of the county board of supervisors, county executive, or county judge. The CEO is responsible for making sure that all the rules about using Ryan White Part A funds are followed. The CEO usually picks an agency to manage the Part A grant—generally the county or city health department. The CEO establishes the planning council and appoints its members.

The Grantee

As the person who receives Ryan White Part A funds, the CEO is the grantee. However, in most EMAs and TGAs, the CEO gives responsibility for administering the grant to a local government

agency (such as a health department) that reports to the CEO. This agency is sometimes also called the grantee. The word “grantee” means the person or organization that actually carries out Ryan White Part A tasks, whether that is the CEO, the public health department, or another agency that reports to the CEO.

The Planning Council

Before the EMA or TGA can receive Part A funds the CEO must appoint a planning council. (The only exception is the five new TGAs that started receiving Part A funds in 2006, as required by the 2006 legislative reauthorization. The CEOs in those TGAs decide whether to form a planning council or obtain consumer and community input in some other way.) The planning council (and its staff) must carry out many complex planning tasks.

The Ryan White legislation requires planning councils to have members from various groups and organizations. At least one third (33 percent) of the planning council members must be PLWHA who receive Part A services and are “unaffiliated.” This refers to consumers who do not have a conflict of interest, meaning they are not staff, consultants, or Board members of Part A-funded agencies.

Separate Roles and Mutual Goals

The Part A planning council and the grantee has separate roles that are stated in the Ryan White legislation, but they also share some duties. The planning council and the grantee work together on identifying PLWHA needs (by conducting a needs assessment) and preparing a comprehensive plan (which is a long-term guide on how to meet those needs).

Both also work together to make sure that other sources of funding work well with Ryan White funds and so that Ryan White is the “payer of last resort.” This means that other available funding should be used for services before Ryan White dollars are used to pay for them.

The planning council alone decides what services are priorities for funding and how much funding should be provided for each service category. The grantee is accountable for managing Part A funds and awarding funds to agencies to provide services that are identified as priorities, usually through a competitive "Request for Proposals" (RFP) process.

The planning council cannot do its job without the help of the grantee, and the grantee cannot do its job without the help of the planning council. Some of the responsibilities are identified clearly in the Ryan White legislation. Others must be decided locally. It is important that the planning council and the grantee work together and come to an agreement about their duties. This agreement should be written in planning council bylaws and in a memorandum of understanding (MOU) between the grantee and the planning council.

Roles of the CEO, Grantee, and Planning Council

Role/Task	CEO/Grantee	Planning Council
Planning Council Formation/Membership	X (CEO)	
Needs Assessment	X	X
Comprehensive Planning	X	X
Priority Setting		X
Directives		X
Resource Allocation		X
Coordination of Services	X	X
Procurement	X	
Contract Monitoring	X	
Clinical Quality Management	X	X (Standards of Care)
Cost-Effectiveness and Outcomes Evaluation	X	X
Assessment of the Efficiency of the Administrative Mechanism		X

HRSA/HAB Division of Service Systems (DSS)

The HRSA HIV/AIDS Bureau's (HAB) Division of Service Systems (DSS) is the office in the Federal government that is responsible for administering Part A and Part B throughout the country.

HRSA is an agency within the U.S. Department of Health and Human Services.

Each EMA or TGA is assigned a Project Officer who works in DSS. Project Officers help the grantee and planning council do their jobs and make sure that they are running the local Part A program as the Ryan White legislation says they should. Project Officers regularly work with both the grantee and the planning council chairs by telephone and through site visits.

PLANNING COUNCIL DUTIES

The planning council (and its staff) must carry out many complex tasks. Described below, the first step for planning councils is to set up rules to help the planning council to operate smoothly and fairly (planning council operations). This includes bylaws, grievance procedures, conflict of interest policies and procedures, procedures that ensure open meetings, and an open nominations process to identify nominees for the planning council. Planning councils must also be trained in planning, and new members must receive orientation to their roles and responsibilities and those of the grantee.

The planning council must find out what services are needed and what populations need care (needs assessment). Next, it decides what services to fund in the EMA or TGA (priority setting) and decides how much Part A money should be used for each of these services (resource allocations). The planning council works with the grantee to develop a long-term plan on how to provide these services (comprehensive plan). The planning council also looks for ways that Part A services work to fill gaps in care with other Ryan White programs (through the Statewide Coordinated Statement of Need or SCSN) as well as other services like Medicaid and Medicare (coordination). The planning council also evaluates how efficiently providers are selected and paid and how well their contracts are monitored (assessment of the efficiency of the administrative mechanism). All these roles are described below.

Planning Council Roles and Responsibilities

- Develop and implement policies and procedures for planning council operations
- Assess needs
- Do comprehensive planning
- Set priorities and allocate resources to service categories, and provide guidance (directives) to the grantee on how best to meet these priorities
- Help ensure coordination with other Ryan White and other HIV-related services
- Assess the administrative mechanism
- Develop standards of care

Planning
Council
Duty

Set Up Planning Council Operations

Planning councils must have procedures to guide their activities. They are usually outlined in their bylaws. They cover such areas as:

- **Membership:** The planning council should form a Membership Committee and use a clear and open nominations process to nominate new planning council members and to replace

members when a member's term ends or the person resigns. Openness requires member vacancies and nomination criteria to be widely advertised. The announcement should include the qualifications and other things that are considered when choosing members. Nomination criteria must include a conflict of interest standard so that the planning council makes decisions without considering personal or professional benefits for members. The planning council reviews nominations against vacancies. It considers the requirements of reflectiveness (having members who have characteristics that reflect the local epidemic) and representation (filling the required membership categories). The planning council recommends members to the CEO for appointment.

- **Training:** Members need to learn how to participate in Ryan White planning. The Ryan White Treatment Modernization Act requires training for planning council members, such as explaining the legislation and their role in planning.
- **Group Process:** This includes a code of conduct, as well as rules for committee and full planning council operations, meeting times, and locations. These are usually described in the bylaws.
- **Decision Making:** The planning council needs to agree on how decisions will be made—for example, by voting or consensus—and how it will handle grievances related to funding decisions and conflict of interest (see below). These rules and procedures are usually described in the bylaws.
- **Conflict of Interest:** The planning council must define conflict of interest and determine how it will be handled as the planning council carries out its duties. The planning council must develop procedures to assure that decisions concerning service priorities and funding allocations are based upon community and client needs and not on the financial interests of individual service provider. Thus, planning councils must decide how planning council members may or may not participate in making decisions about specific services if they are involved with agencies that are receiving Part A funds for these specific services or are competing for such funds. For example, if a planning council member works for a substance abuse provider receiving Part A funds, the member may not participate in decisions about priorities, allocations, or directives related to substance abuse treatment. However, members may freely share their insights in a non-voting context as all members can benefit from hearing a variety of perspectives and expertise.
- **Grievance Procedures:** The planning council must develop grievance procedures to handle complaints about how they make decisions about funding. The grievance procedures must specify who is allowed to file a grievance, types of grievances covered, and how grievances will be handled. (In contrast, the grantee must also have its own grievance procedures, although they are to focus on handling of complaints about funding of providers. Both sets of grievance procedures should be written so that they are not in conflict with one another.)

Planning Council Structure and Bylaws

Chair

Every planning council has a leader, usually called the Chair. This responsibility may be shared by two persons, called Co-Chairs. HAB/DSS suggests that the Chair of the planning council be elected by its members. Sometimes a Chair is appointed by the grantee from the list of members recommended by the planning council. A person who works for the grantee may not be the only Chair of the Council—in this case, there must be Co-Chairs.

Bylaws

Each planning council must have written rules, called bylaws, which explain how the planning council operates. Bylaws must be clear and exact. They should include at least the following:

- Mission of the planning council
- Member terms and how members are selected (open nominations process).
- Duties of members
- Officers and their duties
- How meetings are announced and run, including how decisions are made
- What committees the planning council has and how they operate
- Policies and procedures for handling conflicts of interest
- Grievance procedures
- Code of Conduct for members
- How the bylaws can be amended

Planning Council Support

Planning councils need personnel to assist them in their work and money to pay for things like a needs assessment and meeting costs. Money used for these things is called Planning Council Support.

The planning council's budget is a part of the grantee's administrative budget, so the planning council and grantee decide together what funds are needed and how best to spend them. In deciding how much support to allow, planning councils and grantees should balance the need for such support against the need for direct services for PLWHA.

HAB/DSS encourages planning councils to use planning council support funds to reimburse members who are living with HIV for actual expenses they incur in working as planning council members, such as travel or child care. However, members may not receive stipends.

Assess Needs

The planning council works with the grantee to identify HIV needs by conducting a needs assessment. This involves first finding out how many persons living with HIV disease (both HIV infection and AIDS) are in the area through an epidemiologic profile. Usually, an epidemiologist associated with the health department provides this information. Next the council determines the needs of populations living with HIV disease and the capacity of the service system to meet those needs, through focus groups, surveys, or other methods. This includes determining: (1) the number, characteristics, and service needs of PLWHA who know their HIV status and are not in care; (2) the service needs of people with PLWHA who are in care, including differences in care and needs, particularly for historically underserved populations; (3) the number and location of agencies providing HIV-related services in the EMA or TGA; (4) their capacity and capability to serve PLWHA, including capacity development needs; and (5) availability of other resources and how Ryan White services need to work with these other services, like substance abuse services and HIV prevention agencies.

The needs assessment should be a joint effort of the planning council and grantee but should be led by the planning council. It is sometimes done by an outside contractor under the supervision of the planning council. Usually the costs for needs assessment are part of the planning council support budget. Regardless of who does this work, it is important to obtain many perspectives and to carefully analyze the results.

Set Priorities and Allocate Resources

The planning council next sets priorities. This means the members decide which services to fund. The planning council makes these decisions about priorities for funding based on many factors: (1) the needs assessment; (2) information about the most successful and economical ways of providing services; (3) actual cost and utilization data provided by the grantee; (4) priorities of people living with HIV who will use services; (5) making Part A funds work well with other services like HIV prevention and substance abuse; (6) the amount of funds from other sources like Medicaid, Medicare, and the State Children's Health Insurance Program; and (7) developing capacity for HIV services in historically underserved communities.

Eligible Part A & Part B Services

Core medical services, including:

- Outpatient/ambulatory medical care
- AIDS Drug Assistance Program (ADAP treatments)
- AIDS pharmaceutical assistance (local)
- Oral health (dental) care
- Early intervention services (EIS)
- Health insurance premium & cost-sharing assistance
- Home health care
- Home and community-based health services
- Hospice services
- Mental health services
- Medical nutrition therapy
- Medical case management
- Substance abuse services - outpatient

Support services, including:

- Case management (non-medical)
- Child care services
- Emergency financial assistance
- Food bank/home-delivered meals
- Health education/risk reduction
- Housing services
- Legal services
- Linguistics services (interpretation and translation)
- Medical transportation services
- Outreach services
- Psychosocial support services
- Referral for health care/supportive services
- Rehabilitation services
- Respite care
- Substance abuse services – residential
- Treatment adherence counseling

Definitions for these services may be found on the HRSA/HAB Web site at <http://hab.hrsa.gov> under reporting requirements.

The Planning Council must prioritize only service categories that are included in the Ryan White legislation as core medical services or approved by the Secretary of Health and Human Services as support services. In setting priorities, planning councils need to focus on the legislative requirement that at least 75% of funds go to core medical services and not more than 25% to supportive services. Support services must contribute to positive medical outcomes for clients.

After it sets priorities, the planning council must allocate resources, which means it decides how much funding will be used for each of these service priorities. For example, the planning council decides how much funding should go for primary care services, mental health services, etc

The planning council also has the right to provide “directives” to the grantee on how best to meet the service priorities it has identified. It may direct the grantee to fund services in particular parts of the EMA or TGA (such as outlying counties), or to use specific service models. It may tell the grantee to take specific steps to increase access to care (for example, require that Medical Case Management providers have bilingual staff or that primary care facilities be open one evening or weekend a month). It may also require that services be appropriate for particular populations—for example, it may specify funding for primary care services that target gay men of color. However, the planning council cannot pick specific agencies to fund, or make its directives so narrow that only one agency will qualify. The planning council cannot be involved in any aspect of contractor selection (procurement) or in managing or monitoring Part A contracts.

The planning council works with the grantee to decide on the amount and use of funding needed to support the work of the planning council—to pay for staff, cover planning council and committee costs including PLWHA expenses, and contract for help with activities such as needs assessment. This is called “planning council support,” and it is a part of the EMA or TGA administrative budget.

Once the EMA or TGA receives its grant award for the upcoming year, the planning council usually needs to adjust its allocations to fit the exact amount of the grant. During the year, the grantee usually asks the planning council to approve some reallocation of funds, to ensure that all Part A funds are spent and that priority service needs are met. (See grantee duties, below.)

Planning
Council
Duty

Develop the Comprehensive Plan

The planning council works with the grantee in developing a written plan that defines short- and long-term goals for delivering HIV services in the EMA or TGA. This is called a comprehensive plan. This plan is based, in part, on the results of the needs assessment. It is used to guide decisions about how to deliver HIV/AIDS services for people living with HIV. This plan should be updated every three years, and it should work well with other existing local or State plans. HAB/DSS provides guidance on what the plan should include and when it needs to be completed.

Planning
Council
Duty

Coordinate with Other Ryan White Programs and Other Services

The planning council makes sure that Part A funds work well with other funds, as follows:

The planning tasks described earlier (needs assessment, priority setting and resource allocation, comprehensive planning) require getting lots of input and finding out what other sources of funding exist. This helps avoid duplication in spending and to reduce gaps in care, and helps ensure coordination between HIV prevention and care.

The Statewide Coordinated Statement of Need, called the SCSN, is a way for all Ryan White programs in a State to work together in planning how to use Ryan White funds and avoid duplication of services. Representatives of the planning council—and the grantee—must participate with other Ryan White programs in the State to develop a written SCSN.

Planning
Council
Duty

Assess the Efficiency of the Administrative Mechanism

The planning council is responsible for evaluating how well the grantee gets funds to providers. This means reviewing how quickly contracts with service providers are signed and how long the grantee takes to pay these providers. It also means reviewing whether the funds are used to pay only for services that were identified as priorities by the planning council and the amounts contracted for each service category are the same as the planning council's allocations.

Planning
Council
Duty

Develop Standards of Care and Evaluate Services

Usually the planning council develops standards of care to guide providers in delivering services. The grantee uses these standards of care in monitoring contractors and in determining service quality, as part of its Clinical Quality Management function (described below). Developing standards of care is usually a joint activity, but in most EMAs and TGAs, the planning council takes the lead. To do this, it works with the grantee, providers, consumers, and experts on particular service categories. (Note: These standards of care must be consistent with HHS guidelines on HIV/AIDS care and treatment as well as HRSA/HAB standards and performance measures.)

The planning council may also decide to evaluate how well services funded by Part A are meeting community needs—or pay someone else to do such an evaluation.

CEO AND GRANTEE DUTIES

CEO DUTIES RELATED TO THE PLANNING COUNCIL

The CEO has three important duties related to the Planning Council:

- **Establish the Planning Council:** The CEO must establish the planning council. This includes making sure that the planning council membership overall and the consumer members are similar to the demographics of people living with HIV/AIDS locally (for example, race, ethnicity, age). This is called reflectiveness. Particular attention should be paid to including people from disproportionately affected and historically underserved populations. Planning councils must also include people with specific expertise and backgrounds. This is called representation.

Required Planning Council Membership Categories

- At least 33% PLWHA who receive Part A-funded services (in the cases of minors, their caregivers).
- Health-care providers, including federally qualified health centers.
- Community-based organizations serving affected populations & AIDS service organizations.
- Social service providers (including housing and homeless-services providers).
- Mental health providers.
- Substance abuse providers.
- Local public health agencies.
- Hospital planning agencies or health-care planning agencies.
- Affected communities, including individuals with HIV disease or AIDS, members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C, and historically underserved groups and subpopulations.
- Non-elected community leaders.
- State Medicaid agency.
- State agency administering the Part B program.
- Ryan White grantees under Part C and Part D (If there is no Part D grantee in the EMA or TGA, representatives of organizations in the EMA or TGA with a history of serving children, youth, and families living with HIV).
- Grantees under other Federal HIV/AIDS programs (including HIV prevention programs).
- Formerly incarcerated PLWHA or their representatives.

Planning councils must have consumer participation. By law, at least 33% of the planning council must be PLWHA who receive Part A services. They must also be “unaligned,” meaning they are not staff, paid consultants, or Board members of Part A-funded agencies. These consumers must be reflective of the demographics of PLWHA locally.

- **Choose Planning Council Members:** The CEO establishes the first planning council. After that, the council itself is responsible for identifying and screening candidates that meet the reflectiveness and representation requirements. Once the planning council identifies candidates to fill vacancies, it forwards their names and other requested information to the CEO for consideration for appointment. The CEO retains sole responsibility for appointment of all members to the planning council.
- **Review and Approve Bylaws and Other Processes:** The CEO establishes the planning council and thus has the authority to review and approve planning council bylaws and other policies. Often, the planning council is considered an official board or commission of the city or county. Its bylaws and procedures must fit the policies established for these boards and commissions as well as meeting Ryan White legislative requirements.

GRANTEE DUTIES

The grantee has planning duties, which include assisting the planning council with needs assessment and comprehensive planning, and providing information and advice that helps the planning council in deciding how to allocate funds. The grantee also has administrative duties, which means that it is responsible for making sure that Part A funds are fairly and correctly managed and used. These duties are described below.

GRANTEE PLANNING DUTIES

Shared Planning Council and Grantee Responsibilities

- Carry out a needs assessment.
- Develop a comprehensive plan.
- Coordinate with other Ryan White programs and other services—participate in the Statewide Coordinated Statement of Need (SCSN) —and ensure that Ryan White funds are coordinated with other funding sources like prevention and substance abuse
- Reallocate funds as necessary.

Grantee
Planning
Duty

Support Planning Council Members

Both the planning council and the grantee have the responsibility to support the participation of people living with HIV disease on the planning council. Examples include reimbursing their travel and child care costs. They must also train planning council members about their roles and responsibilities so they can be effective members.

The grantee must cooperate with the planning council by providing information that the planning council needs to carry out its responsibilities, particularly information it needs to assess the efficiency of the administrative mechanism.

Grantee
Planning
Duty

Assess Needs

The grantee works with the planning council to assess the needs of communities affected by HIV/AIDS.

Grantee
Planning
Duty

Develop the Comprehensive Plan

The grantee and planning council work together to develop a comprehensive plan for the organization and delivery of HIV services. This plan must be compatible with existing State and local plans.

Grantee
Planning
Duty

Coordinate With Other Ryan White HIV/AIDS Programs and Other Services

Both the grantee and planning council work together to make sure that Part A funds work well with other funds. This occurs through planning. For example, the needs assessment and comprehensive plan need to find out what HIV prevention and substance abuse services already exist and work with them in serving PLWHA. It also occurs through the

Statewide Coordinated Statement of Need (SCSN), which is a way for all Ryan White programs in a State to work together in planning the use of Ryan White funds to provide services and avoid duplication.

GRANTEE ADMINISTRATIVE DUTIES

Below are Part A grantee duties to make sure that funds are used fairly and appropriately.

Grantee
Admin.
Duty

Establish Intergovernmental Agreements (IGAs)

The grantee must make sure that Part A funds reach all communities in the EMA or TGA where need exists. Thus, it must establish formal, written agreements with cities and counties within the EMA or TGA that provide HIV-related services and also account for at least 10 percent of the EMA's or TGA's reported AIDS cases. This agreement is called an Intergovernmental Agreement (IGA.) An IGA should describe how Part A funds will be distributed and managed.

Grantee
Admin.
Duty

Distribute Funds According to Planning Council Priorities

The grantee must distribute Part A funds according to the priority setting and resource allocations decided by the planning council. (An exception is funds that the grantee decides to use for its own administrative expenses.) In addition, the grantee must follow planning council directives about “how best to meet” priority needs. In contracting for services, the grantee can only spend the amount of money that the planning council decides should be used for that priority.

Grantee
Admin.
Duty

Establish Grievance Procedures

The grantee must develop grievance procedures to handle complaints about funding, such as the process by which contractors are chosen. Like the planning council's grievance procedures, they must specify who is allowed to file a grievance, types of grievances covered, and how grievances will be handled.

Grantee
Admin.
Duty

Ensure Services to Women, Infants, Children, and Youth with HIV Disease

The grantee must assure that the percentage of money spent on serving women, infants, children, and youth with HIV disease is at least in proportion to how much each group represents among the total HIV/AIDS cases in the EMA or TGA. An exception is allowed when the grantee can show that their needs are met through other programs like Medicaid or Medicare. The planning council must consider this requirement when setting priorities and allocating resources.

Grantee Administrative Duties

- Establish intergovernmental agreements (IGAs) with other cities/counties in the EMA or TGA where required
- Distribute funds according to planning council priorities and allocations
- Establish grievance procedures to address funding-related decisions
- Ensure delivery of services to women, infants, children, and youth with HIV disease
- Ensure that Ryan White funds do not pay for care that is paid for elsewhere
- Ensure that services are available and accessible to eligible clients
- Carry out clinical quality management activities to ensure that services are of high quality
- Prepare and submit Part A funding application
- Limit grantee and provider administrative costs
- Monitor contracts
- Reallocate funds with the approval of the planning council, to ensure that all funds are spent and used efficiently and appropriately

Grantee
Admin.
Duty

Ensure That Ryan White Funds are Used to Fill Gaps

Part A grantees must ensure that funds do not pay for services that are funded by other sources and that Part A funds are not used to replace local spending on HIV/AIDS care. This is because the Ryan White Treatment Modernization Act is the “payer of last resort.” This means, for example, that the grantee must require contractors such as clinics to make sure clients are not eligible for Medicaid or some other source of funding before they use Part A funds to pay for their care. This requirement makes sure that Ryan White funds are used to assist PLWHA who do not have any other source of payment for the services they need.

Grantee
Admin.
Duty

Ensure Availability and Accessibility of Services to Eligible Clients

Part A grantees must ensure that Part A services are available, regardless of an individual's health condition or ability to pay and in settings that are accessible to low-income people with HIV.

Outreach must be provided to inform people of the availability of services and to link them to care. One of the most important priorities of the Ryan White legislation is to find people who know they are HIV-positive but are not receiving regular HIV-related medical care, and help them to get into care, and stay in care.

Providers receiving Part A funds must be required to work with other providers so that services are easier for clients to get. This network of providers is called a “continuum of care.” As part of this, providers should make it easy for clients to get into care as early as possible by maintaining “appropriate relationships with entities that constitute key points of access to the health care system.” Key points of access include, for example, emergency rooms, substance abuse treatment programs, and sexually transmitted disease clinics.

Grantee
Admin.
Duty

Carry Out Clinical Quality Management Activities

The grantee must establish a clinical quality management program that measures how providers are using standards of care for their services, and if services are consistent with those guidelines. Quality management also looks at client satisfaction with the services they receive. If a funded provider is not meeting the standards of care established for its service category, the grantee will work with the provider to develop a quality improvement plan, and then monitor how the provider carries out the plan to improve services. As part of quality management, the grantee often evaluates clinical outcomes—for example, whether clients receiving Part A services have improved CD-4 counts.

Grantees can use up to 5% of the award to conduct quality management programs. The grantee shares with the planning council the results of its quality management activities. The planning council receives information by service category, but not information about individual providers. This quality management data helps the planning council in priority setting and resource allocations.

Grantee
Admin.
Duty

Prepare and Submit Part A Applications

The grantee is responsible for preparing and submitting a Part A application and the MAI application to the Federal government. Although this is the grantee's responsibility, the planning council should participate in the preparation of this application because the application requires information about the planning council and how it works. The chair(s) of the planning council must certify in writing to HAB/DSS that the priorities in the application are the ones developed by the planning council. They must also verify that the grantee spent funds in the past year according to the planning council's decisions.

Grantee
Admin.
Duty

Limit Grantee Administrative Costs

The grantee may use up to 10% of the Part A grant for managing the Part A program and for other administrative duties, as well as for planning council support. Examples of administrative duties include writing applications, preparing reports, and activities involving payout of Part A funds (including reviewing provider applications, negotiating and monitoring contracts, and paying providers).

Grantee
Admin.
Duty

Limit Quality Management Costs

The grantee may use up to 5% of the grant for quality management activities.

Grantee
Admin.
Duty

Limit Contractor Administrative Costs

The grantee must ensure that local providers, subcontractors, and other entities, collectively, spend not more than 10% of total Part A grant funds for administrative expenses.

Grantee
Admin.
Duty

Monitor Contracts

The grantee must make sure that the providers who receive Part A funds use the money according to the terms of the contract they signed with the grantee. The grantee monitors providers to determine how quickly they spend Part A funds, if they are performing the services, and if they are using funds only as approved, meeting reporting and other contract requirements.

Grantee
Admin.
Duty

Reallocate Funds

The grantee and the planning council must keep track of how rapidly Part A money is, or isn't, being spent. If funds are not being spent in a timely fashion, there are two options: (1) the grantee may reallocate the funds to another provider within the same service priority, or (2) the planning council may agree to reallocate funds to a different service priority. The grantee and the planning council must work together to share information and ensure that any changes are in agreement with the priorities and allocations established by the planning council.

Grantee
Admin.
Duty

Technical Assistance

The grantee and planning council may ask their Project Officer for technical assistance from HAB/DSS to help them develop skills needed to meet the responsibilities outlined in this primer. If the grantee or the planning council needs help in fulfilling its duties, HAB/DSS can provide it. HAB/DSS can provide information that describes what other EMAs or TGAs have done, or it can provide experts to work over the phone or on-site with the grantee or the planning council.

Examples of technical assistance include supporting participation of people living with HIV in Ryan White planning, needs assessment, committee structures and operations, and working effectively with the grantee. Requests for technical assistance must be made in writing to the HAB/DSS Project Officer, either by the grantee or by the planning council with grantee approval or notification. For more information, visit the TARGET Center, the HRSA HIV/AIDS Bureau's website for accessing Ryan White TA and training, at <http://careacttarget.org>. Also learn more about the Ryan White HIV/AIDS Program at <http://hab.hrsa.gov>.