



**Solicitation Information
19 February 2014**

RFP# HIVRW14-1

TITLE: HIV Provision of Care/Ryan White Services

Submission Deadline: 11 April 2014 (1:00 PM)

There will be a technical assistance regarding this RFP on Friday, 28 February from 12-2 PM in the Garden Conference Room at the Hazard building (74 West Road, Cranston, RI 02920). Questions concerning this solicitation must be received by the Executive Office of Health & Human Services at Christopher.Botelho@ohhs.ri.gov no later than **4 March 2014. Questions should be submitted in a *Microsoft Word attachment*. Please reference the RFP# on all correspondence. Questions received, if any, will be posted on:**
<http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/Adults/RyanWhiteHIVCareProgram/RequestforProposals.aspx> as an addendum to this solicitation. It is the responsibility of all interested parties to check the questions throughout the posting time and download this information accordingly. **No other contact with State parties will be permitted.**

SURETY REQUIRED: No

BOND REQUIRED: No

NAME OF BUYER: RI Executive Office of Health and Human Services, Medicaid Division

NAME OF CONTACT PERSON: Paul Loberti, c/o Christopher Botelho, Program Assistant

TITLE OF CONTACT PERSON: Administrator, HIV Provision of Care

Applicants must register on-line at the State Purchasing Website at www.purchasing.ri.gov

Note to Applicants:

Proposals received without the entire completed four-page RIVIP Generated Bidder Certification Form attached may result in disqualification. *All attachments referenced herein will be posted on the EOHHS website and can be found on the Ryan White RFP page at:*

<http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/Adults/RyanWhiteHIVCareProgram/RequestforProposals.aspx>

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

TABLE OF CONTENTS

Section 1: Introduction	3
Section 2: Background and Purpose	4
The National HIV/AIDS Strategy (NHAS)	6
The Treatment Cascade/HIV Continuum of Care	8
Procurement Objective and Process	12
Ryan White Modernization Act Framework for Allowable Costs and Services.....	12
Summary of Conditions for Service Provision	14
Section 3: Scope of Work.....	16
General Scope of Work	16
Specific Activities / Tasks	19
Section 4: Technical Proposal	31
Section 5: Cost Proposal.....	37
Detailed Budget and Budget Narrative.....	37
Line Item Budget Proposal.....	37
Section 6: Evaluation and Selection	40
Section 7: Proposal Submission	42

SECTION 1: INTRODUCTION

Under delegated authority, the Rhode Island Executive Office of Health and Human Services, Medicaid Division, HIV Provision of Care Program (herein referred to as EOHHS), on behalf of the Department of Administration (DOA)—is soliciting proposals from qualified non-profit organizations to provide comprehensive core medical and/or support services to low-income persons living with HIV/AIDS (PLWH/A) in Rhode Island; as described elsewhere herein, in accordance with the terms of this Request for Proposals and the State's General Conditions of Purchase, which may be obtained at the Rhode Island Division of Purchases Home Page by Internet at www.purchasing.ri.us. The contract period will begin 1 July 2014 through 31 June 2015. Contracts may be renewed for up to two additional 12-month periods based on vendor performance and the availability of funds.

This is a Request for Proposals, not an Invitation for Bid. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to price; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

1. Potential vendors are advised to review all sections of this RFP carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.
2. Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this RFP will be rejected as being non-responsive.
3. All costs associated with developing or submitting a proposal in response to this RFP, or to provide oral or written clarification of its content shall be borne by the vendor. The State assumes no responsibility for these costs.
4. Proposals are considered to be irrevocable for a period of not less than 120 days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.
5. All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.
6. Proposals misdirected to other state locations, or which are otherwise not present in the Executive Office of Health & Human Services at the time of opening for any cause will be determined to be late and will not be considered. For the purposes of this requirement, the official time and date shall be that of an atomic time clock at EOHHS.
7. It is intended that an award pursuant to this RFP will be made to a prime vendor, or prime vendors in the various categories, who will assume responsibility for all

aspects of the work. Joint venture and cooperative proposals will not be considered. Subcontracts are permitted, provided that their use is clearly indicated in the vendor's proposal and the subcontractor(s) to be used is identified in the proposal.

8. All proposals should include the vendor's FEIN or Social Security number as evidenced by a W9, downloadable from the Division's (DOA) website at www.purchasing.ri.gov.
9. The purchase of services under an award made pursuant to this RFP will be contingent on the availability of funds.
10. Vendors are advised that all materials submitted to the State for consideration in response to this RFP will be considered to be Public Records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island, without exception, and will be released for inspection immediately upon request once an award has been made.
11. Interested parties are instructed to peruse the Executive Office of Health & Human Services website (<http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/Adults/RyanWhiteHIVCareProgram/RequestforProposals.aspx>) on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP.
12. Equal Employment Opportunity (G.L. 1956 § 28-5.1-1, et seq.) – § 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies to all areas where State dollars are spent, in employment, public services, grants and financial assistance, and in state licensing and regulation. For further information, contact the Rhode Island Equal Opportunity Office at (401) 222-3090.
13. In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful vendor(s).
14. The vendor should be aware of the State's Minority Business Enterprise (MBE) requirements, which address the State's goal of ten percent (10%) participation by MBE's in all State procurements. For further information, contact the MBE Administrator at (401) 574-8253 or visit the website www.mbe.ri.gov or contact charles.newton@doa.ri.gov.

SECTION 2: BACKGROUND

Funding shall be made available for this initiative via a variety of funding sources, including HRSA(Health Resources and Services Administration) HIV/AIDS Bureau (HAB),

Part B funds associated with the federal Ryan White HIV/AIDS Treatment Modernization Act of 2006 (PL 109-415). Part B, via the granting agency, HRSA, provides grants to all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five (5) U.S. Pacific Territories or Associated Jurisdictions. In 2009, Congress passed a bill that makes minor changes to the Ryan White HIV/AIDS Program and reauthorizes it through fiscal year 2013. The President signed the bill (PL 111-87) on October 30, 2009. The remaining funds will be available through drug rebate funds as well as through state matching funds (which allow for federal funds to supplement the state match from CMS) for the Medicaid case management portion of this RFP.

The emphasis of Part B of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and the 2009 reauthorization is on providing life-saving and life-extending services for low-income people living with HIV/AIDS (PLWH/A). Specifically, the purpose of this legislation is to develop and/or enhance access to a ***comprehensive continuum of high quality, community-based care*** for low-income PLWH/A. PL 111-87 requires Ryan White Part B Programs to develop strategies, coordinated as appropriate with other community strategies, and efforts for identifying PLWH/A who do not know their status, making such individuals aware of their status, and enabling such individuals to use the health and support services; with particular attention to reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities. It also retains the requirement that there is a current plan for finding PLWH/A not in care and getting them into primary care.

It is a requirement of HRSA that 75 percent of the Part B funds each state receives must be used to fund “core medical services”, defined as a set of essential, direct health care services provided to PLWH/A and specified in the Ryan White HIV/AIDS Treatment Modernization Act. “Core medical services” in Rhode Island are limited to: outpatient/ambulatory medical care, oral healthcare, health insurance premium assistance, home and community-based health services, mental health services, medical nutrition therapy, and transitional/medical case management services (including treatment adherence and referral for health care/supportive services) for incarcerated individuals. These services assist PLWH/A in accessing treatment of HIV infection that is consistent with US Department of Health & Human Services (HHS) Treatment Guidelines (www.aidsinfo.nih.gov). These guidelines include ensuring access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections as well as combination antiretroviral therapies.

The remaining 25% of Part B funds must go to “support services”, defined as a set of services needed to achieve medical outcomes that affect the HIV-related clinical status of PLWH/A. “Support services” in Rhode Island are limited to: non-medical case management services (including referral for health care/supportive services), emergency financial assistance, food bank/home-delivered meals, medical transportation services, psychosocial support services. This continuum of care includes only those services that enable individuals to access, and remain in primary medical care. As noted above, while applicants may bid on non-core medical services listed herein, the state must insure that 75% of total funds are directed towards core medical services. Therefore priority shall be given to core medical services. ***Applicants need to review the newest policy statements 13-01 through***

13-06 from HRSA/HAB that relate to the Affordable Care Act. Go to <http://hab.hrsa.gov/manageyourgrant/policiesletters.html> for the following statements:

13-06 Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid

13-05 Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance

13-04 Clarifications Regarding Clients Eligible for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program

13-03 Ryan White HIV/AIDS Program Client Eligibility Determinations: Considerations Post-Implementation of the Affordable Care Act

13-02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertification's Requirements

13-01 Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by Ryan White HIV/AIDS Program

If applicants choose to utilize Part B funds in accordance with the aforementioned HRSA policies, they need to be specific as to the goals and objectives, and reference the HRSA policy statements by name and number. Please associate the policy statement within any goals and objectives, such that the reviewers completely understand your proposal's intent to utilize the HRSA policy authority..

Summary of Funding Priorities of the Healthcare Resources and Services Administration (HRSA)

- Core Medical Services: 75% of Ryan White Part B funds awarded to the State must be spent for core services.
- Priority Populations: In 1996 Congress established four priority populations under the Ryan White Program to ensure that an amount of Part B funds be used to provide services(including treatment measures to prevent perinatal transmission of HIV) proportionate to the number of women, infants, children and youth (WICY) living with HIV disease in each state. Definitions are as follows:
Infants: under 2 years
Children: 2 – 12 years
Youth: 13 – 24 years
Women: 25 and older

The National HIV/AIDS Strategy (NHAS)

Applicants must fully understand and exemplify the NHAS in their proposals. In July 2010, the White House released the National HIV/AIDS Strategy (NHAS). The NHAS has three primary goals:

1. Reduce New Infections

- ❖ Lower the annual number of new infections by 25%
- ❖ Reduce HIV transmission by 30%
- ❖ Increase the percentage of people living with HIV who know their serostatus from 79% to 90%

2. Increase Access to Care and Improve Health Outcomes for People Living with HIV

- ❖ Increase the proportion of newly diagnosed patients linked to clinical care from 65% to 85%
- ❖ Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73% to 80%
- ❖ Increase the number of Ryan White clients with permanent housing from 82% to 86%

3. Reduce HIV-Related Health Disparities

- ❖ Improve access to prevention and care services for all Americans
- ❖ Increase the proportion of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%
- ❖ Increase the proportion of HIV-diagnosed Blacks with undetectable viral load by 20%
- ❖ Increase the proportion of HIV-diagnosed Latinos with undetectable viral load by 20%

The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically utilized. Further, and relevant to this funding opportunity announcement, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, they often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV.

To ensure success, the NHAS requires the Federal government and State, tribal and local governments increase collaboration, efficiency, and innovation. Therefore, to the extent possible, Ryan White HIV/AIDS program activities should support the three primary goals of the NHAS. The Part B Early Identification of Individuals with HIV/AIDS (EIIHA) requirement and the Centers for Disease Control and Prevention's (CDC) Enhanced Comprehensive HIV Prevention Plan (ECHPP) are two Federal initiatives that support the NHAS. Go to <http://aids.gov/federal-resources/national-hiv-aids-strategy/overview> for more information on NHAS.

All applicants must describe how their work is aligned with the goals of the NHAS. We recommend that in the goals and objectives section of the written proposal you submit, that

NHAS is predominantly detailed so each of the above stated three, NHAS goals are incorporated into your proposals. You may reference the state's HIV epidemiologic profile at <http://www.health.ri.gov/publications/epidemiologicalprofiles/2012HIVAIDSViralHepatitisWithSurrogateData.pdf> to ascertain Rhode Island data relevant to your agency's goals. Before this incorporation is done, please read the below section on the treatment cascade/HIV continuum of care so that the NHAS goals integrate with the treatment cascade elements.

The Treatment Cascade/HIV Continuum of Care

The HIV Provision of Care Unit (Medicaid Division) at EOHHS is statutorily responsible for HIV care within the state. The HIV/AIDS treatment cascade (also referred to as the HIV continuum of care) is a way to show, in visual form, the numbers of individuals living with HIV/AIDS who are actually receiving the full benefits of the medical care and treatment they need.

This model was first described by Dr. Edward Gardner and colleagues, who reviewed current HIV/AIDS research and developed estimates of how many individuals with HIV in the U.S. are engaged at various steps in the continuum of care from diagnosis through viral suppression. Their analysis, published in the March 2011 edition of the journal *Clinical Infectious Diseases* (<http://cid.oxfordjournals.org/content/52/6/793.full.pdf+html>), found that along each step of the cascade, a significant number of people living with HIV in the U.S. "fall off", and only a minority of persons with HIV actually achieve suppression of their viral infection.

Subsequently, in late 2011 CDC did its own analysis of HIV surveillance datasets, viral load and CD4 laboratory reports, and other published data to develop national estimates of the number of HIV-infected persons at each step of the treatment cascade. Their findings, published in CDC's *Morbidity and Mortality Weekly Report* (MMWR), can be summarized as follows:

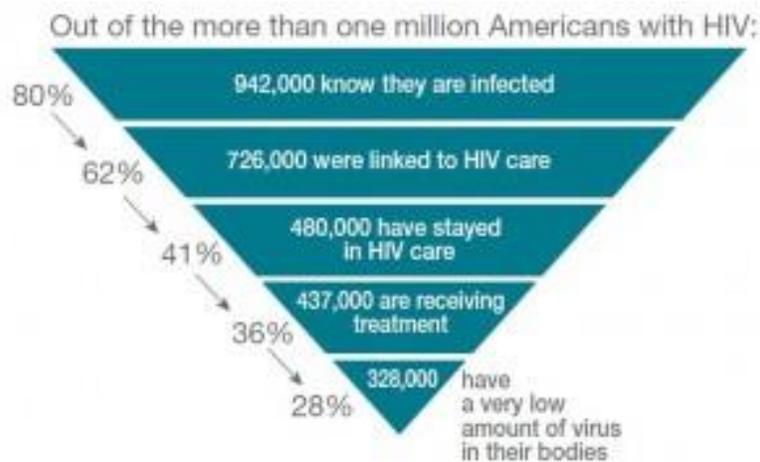
For every 100 individuals living with HIV in the United States, it is estimated that:

- 80 are aware of their HIV status
- 62 have been linked to HIV care
- 41 stay in HIV care
- 36 get antiretroviral therapy (ART)
- 28 are able to adhere to their treatment and sustain undetectable viral loads

In short, CDC estimated that only 28 percent of the more than 1 million individuals in the U.S. who are living with HIV/AIDS are getting the full benefits of the treatment they need to manage their disease and keep the virus under control. Put another way, nearly 3 out of 4

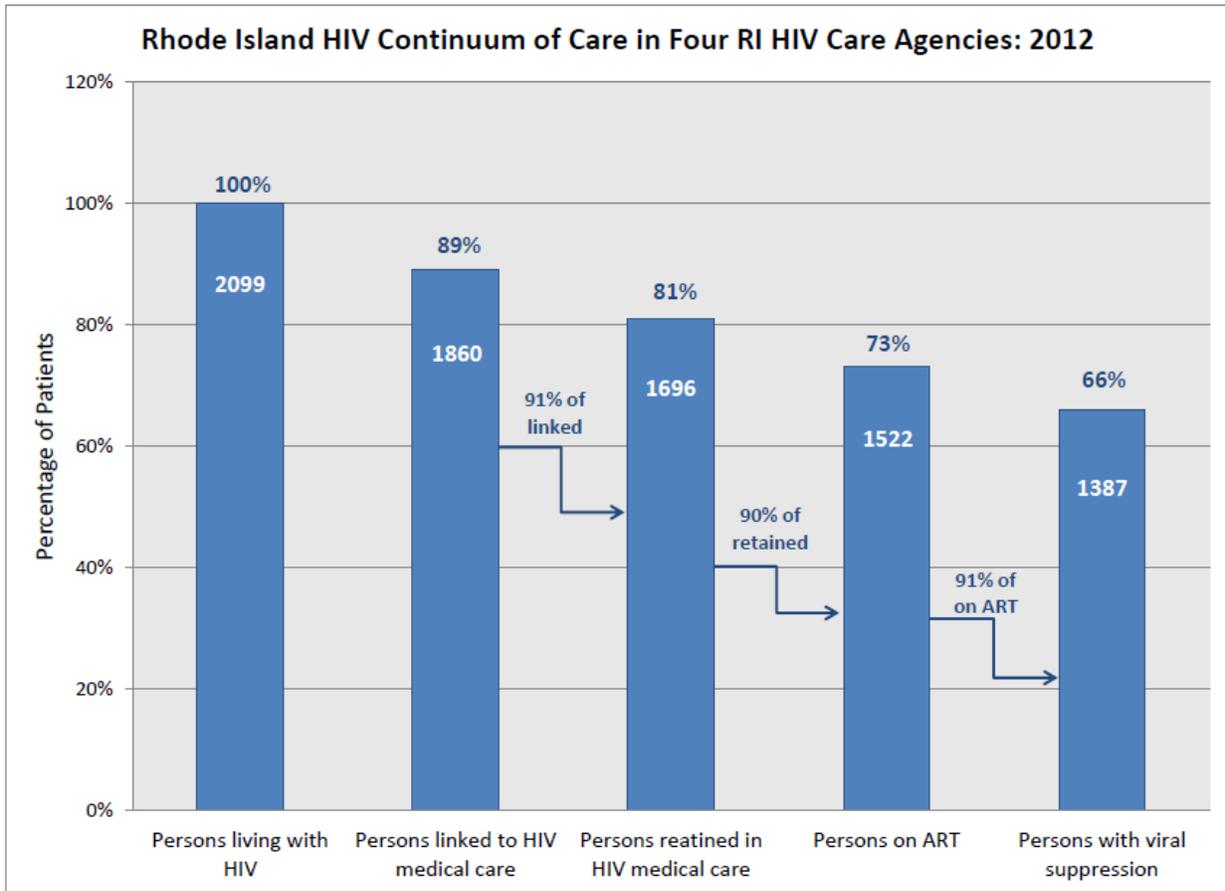
people living with HIV in the U.S. have failed to successfully navigate the treatment cascade. As colleagues at the CDC have noted, to meet the goals of the National HIV/AIDS Strategy and break the cycle of HIV transmission in the United States we must achieve high levels of engagement at every stage in the continuum [associated with the treatment cascade].

Since a picture “is worth a thousand words,” consider this representation from a new CDC fact sheet on Today’s HIV Epidemic in the U.S.:



[For more information on the treatment cascade, read CDC’s Vital Signs brief on the treatment cascade and the related MMWR reviewing their own analysis of the proportion of Americans living with HIV at each step in the cascade.]

In Rhode Island, we have begun to estimate the outcomes associated with the HIV continuum of care. The following chart represents some very preliminary findings provided by HIV care agencies, found on the following page:



The data above was received from four agencies providing HIV care made up of both Ryan White funded agencies and non-Ryan White funded agencies. Data was provided to EOHHS as well as the Department of Health (HEALTH), and combined here with prevalence data from the RI Epidemiologic profile, providing the results in the HIV continuum of care/treatments cascade graphic display presented above. Data is reflective of calendar year 2012 (January 1, 2012 to December 31, 2012). Persons retained in HIV medical care is defined by HRSA as individuals who have had at least two (2) visits with an HIV physician within a 12 month period, at least three (3) months apart. Viral suppression is defined by HRSA as having a viral load of less than 200 copies/mL at the most recent viral load test. *Note: This data does not include people living with HIV in the state of RI that are unaware of their status. "Persons living with HIV" refers to those that have a known HIV infection.*

How is the HIV/AIDS treatment cascade being used?

At the Federal level, government agencies use the treatment cascade to inform discussions about how best to prioritize and target resources. For example, the treatment cascade points to the importance of continuing to support the adoption of routine HIV testing of all adults and adolescents in medical care settings, as was first recommended by the CDC in 2006. Simply stated, we won't be able to link more individuals with HIV/AIDS into care if we can't diagnose them!

At the State and local levels, program planners also apply the treatment cascade—using local data—to assess where resources are needed and then to target them accordingly. For example, the Los Angeles County Department of Public Health produced a program brief (<http://publichealth.lacounty.gov/aids/reports/TLCBrief4-12.pdf>) summarizing data on the spectrum of engagement in care and treatment for all persons infected with HIV in LA County. Similar analysis has been done in San Francisco, Chicago, Washington, DC and other communities, enabling them to take steps to improve engagement at each step in the continuum of HIV care.

The above is referenced from Dr. Ronald Valdiserri’s (Assistant Secretary of Health & Human Services) BLOG.AIDS.GOV

It is the intent of this RFP to have all applicants fully understand and engage in to the treatment cascade. To that end each applicant must answer the following questions within their goals and objectives section of the RFP. Please be certain to describe methodology for data collection, list all relevant and appropriate data, and sources of information.

1. How does your agency assist the state in identifying newly diagnosed individuals? What are your outreach and testing strategies and programs to identify unawares?
2. If you encounter a client who is HIV positive and not in treatment, what steps does your agency take to refer and/or link the client to care?
3. What short-term and long –term follow-up procedures does your agency complete to verify the referral or care connection was made?
4. If you are either a case management agency or a health care provider, what percent of the PLWH/A in your agency are documented as being virally suppressed (as indicated by undetectable viral loads)?
5. What percent are currently linked to care (a specific reference has been made declaring a linkage to care; e.g., they have a physician that they have seen, etc.)?
6. What percent of patients/clients are documented as currently receiving ARV treatment and are seeing a physician?
7. List the average number of visits each client/patient makes to their physician within a six month phase, within a one year period; and if available over a two year span.
8. What percent of clients/patients are documented as being out of care? Specifically what percent of clients/patients in your agency/practice have not seen a physician in the last year? Two years or more?
9. When a client is discovered to be out of care, what re-engagement strategies does your agency follow and complete to get the client/patient back into care?
10. What are the statistics regarding severity/acuity indexing? For example, describe your severity/acuity indexing scales ,providing specific reasons for moderate/high acuity based on your agency experiences,and what the aggregate data indicate. Specifically, describe the number and percentage of clients within a one year time

frame from 1 April 2012 – 31 March 2013, that fall into the following categories a) low severity/acuity, b) moderate severity/acuity, b) high severity/acuity.

Applicants may further explore and expound upon the cascade, and if they do so please be specific with supplying data and other information.

Procurement Objective and Process

The objective of this Request for Proposals (RFP) is to procure the services of qualified non-profit community-based organizations that have the expertise to provide core medical and/or support services to people living with HIV/AIDS (PLWH/A) living in the state of Rhode Island, in accordance with federal and state Ryan White Part B requirements.

EOHHS anticipates spending approximately \$2,001,829 in the first year of the project. It is anticipated that the first year project period will begin on 1 July 2014 and end on 30 June 2015. This amount may be increased, decreased, or withdrawn entirely based on actual awards received by EOHHS. Once vendors are selected, consideration will be given to modifying contract amounts based on need for services within the contract's scope of services, contractor performance, and availability of funding.

Ryan White Part B funds are defined as being any funds utilized by EOHHS for the provision of Ryan White HIV care services, regardless of their source (federal, state, rebate, or other funds). EOHHS reserves the right to modify the scope of services within a contract, at any time, based on the availability of funding, contractor performance and new and/or modified federal or state requirements.

EOHHS will renew the project on an annual basis for up to two (2) additional one-year terms, subject to federal requirements, contractor performance, compliance with the terms and conditions of the contract, and availability of funds. EOHHS reserves the right, at any time during the term of the resultant award pursuant to this solicitation, to expand and/or reduce the base engagement. Contractors must adhere to the federal Ryan White legislative intent and HRSA Ryan White Part B policy regarding allowable services, cost effectiveness, coordination of care, and payer of last resort requirements. All applicants must understand the Monitoring Standards associated with HRSA and incorporate these standards into their proposals. The HRSA Ryan White Part B Monitoring Standards can be found at (<http://hab.hrsa.gov/manageyourgrant/files/programmonitoringpartb.pdf>) or on the EOHHS Ryan White RFP page at (<http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/Adults/RyanWhiteHIVCareProgram/RequestforProposals.aspx>). If a vendor is determined to be fraudulent in their use of Ryan White funds, the state has the right to request back payment and further invoke fiscal penalties to the vendor.

Ryan White Modernization Act Framework for Allowable Costs and Services

The federal Ryan White HIV/AIDS Treatment Modernization Act requires that services be provided in a manner that are coordinated, cost effective, and ensures that Ryan White Part B funds are the “payer of last resort.” Cost effectiveness includes two interrelated

dimensions: outcomes and costs. Ryan White Part B programs are required to accomplish positive results (be effective) and to do so at reasonable cost (be cost effective).

Ryan White stipulates that funds cannot be used to make payments for any item or service where payment can reasonably be expected to be made by sources other than Ryan White funds. Ryan White services are the “payer-of-last resort”, meaning that they fill in gaps **not covered** by other resources. At the individual client level, this means that contractors must make efforts to secure non-Ryan White Part B funds whenever possible for services to individual clients. In support of this intent, all services funded under this RFP must include a central function ensuring that eligibility for other funding sources is aggressively and consistently pursued.

In every instance, EOHHS expects that services funded through this RFP will fall within the federal Ryan White-defined range of services. These are limited to those services specifically selected by the state. The goal and the burden of proof of the applicant is to meet documented needs and gaps; contribute to the establishment of a continuum of care for PLWH/A in Rhode Island; to follow the elements in the treatment cascade which are outlined herein; to reveal positive quality management outcome via performance measures; and to provide available and accessible services to PLWH/A. Ryan White funds are intended to support only the HIV related needs of eligible individuals. Contractors must be able to make an explicit connection between any service supported with Ryan White funds and the intended recipients’ HIV status. To be specific, all funded Ryan White agencies within the state must be able to describe in full the extent of interconnectedness with each other and with other agencies that are part of their referral system for care and services. Memorandum of Understanding (interagency agreements, etc.) describing present and future relationships are desirable and should be linked to the continuum of care.

Applicants are reminded that, if awarded funds through this RFP, it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in the Public Health Service (PHS) Grants Policy Statement, copies of which are available online at <http://www.hrsa.gov/grants/default.htm> (click on “HHS Policy Statement” in the right-hand menu box). In the case of services being supported in violation of an existing federal policy (e.g. payment of home mortgages), the use of Ryan White Part B funds will be terminated immediately and the contractor may be required to return already-spent funds to the federal government.

In no case may Ryan White Part B funds be used to make direct payments of cash to recipients of services (i.e. clients). Where direct provision of the service is not possible or effective, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g. transportation) must be used. Contractors are advised to administer voucher programs in a manner, which assures that vouchers cannot be used for anything other than the allowable service, and that systems are in place to account for disbursed vouchers.

In addition, Ryan White Part B funds may not be used to purchase clothing; employment, vocational, or employment readiness services; funeral, burial, cremation, or related expenses; direct maintenance expenses (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or

license and registration fees; local or state personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied; and off-premise social and/or recreational activities or to pay for a client's gym membership.

The principle intent of the Ryan White HIV/AIDS Treatment Extension Act of 2009 is to provide services to persons infected with HIV, including those whose illness has progressed to the point of clinically defined AIDS. Contractors are expected to establish and monitor written procedures to ensure that client eligibility for Part B services are verified and documented. To be eligible for funded Ryan White Part B services in Rhode Island, an individual must be a verified resident of Rhode Island, have a verified and documented HIV diagnosis, and a verified gross family income less than 400% of the most current federal poverty level (FPL).

It is not necessary to be a citizen of the United States to receive services. If an applicant proposes additional eligibility requirements for their clients, those requirements must be described in their proposals. Contractors awarded funds through this RFP are expected to establish written policies and protocols for determining eligibility for Ryan White funded services, which must be approved by EOHHS. Applicants must demonstrate experience and proficiency in serving PLWH/A. They must also demonstrate the ability to commence services on 1 July 2014.

Summary of Conditions for Service Provision

The successful agency must insure that:

- Proof of HIV diagnosis is documented in the client record
- Written authorization is obtained from each client prior to provision of service and that this is updated at least annually.
- Income status of clients is obtained using MAGI; or in the case of undocumented individuals, an acceptable methodology and/or process approved by EOHHS that can be verified through written documentation maintained in the client record and that this is updated every six months.
- Recertification of all Ryan White clients/patients is done every six months.

A service or program is considered cost effective when the unit cost is reasonable and acceptable relative to the benefits and outcomes received. Definitions of Unit of Service: In general, a unit is defined as a single procedure, service or item. Although the state of Rhode Island no longer accepts unit cost billing for case management, a case management unit can still be viewed and reviewed within the increments of providing services to a client. It is critical that all case management agencies have an acuity or severity index to determine client gravity/intensity. This index should specifically outline necessary and essential services assigned to varying levels of the index. All client/patient charts must clearly note severity. For example, a low index client will require less time and effort from a case manager as the client's care plan is implemented. A case with a higher index may require more time and effort. A mileage unit is defined as one mile. Wait time units are defined as 1 hour (which may be broken down into quarter hours). These units shall be instrumental as successful applicants develop their Implementation Plan required by HRSA.

Note for salaried services:

- ❖ Unlike billing where items or services are procured, the units delivered under salaried services are used to justify the time purchased under the scope of Ryan White Part B. The amount of service provision time, as measured in units, should equal at least 75% of the salaried time procured. The other 25% of time is for activities such as staff meetings, clinical supervisions sessions, training, Consortium meetings, etc.
- ❖ A service may be considered cost effective if it can be provided less expensively than other similar services, but provides an equal or better outcome.
- ❖ A service is cost effective if it provides an additional benefit worth the additional cost.

- Subcontractors shall not use funds under the scope of this proposal to provide care to persons or individuals with family incomes greater than the Rhode Island Ryan White FPL income limit.
- Insurance status of clients is verified through written documentation maintained in the client record and that this is updated at least every six months.
- All services must be delivered in a client centered and culturally appropriate manner and provided in a setting that is accessible to low-income individuals with HIV disease.
- HIV related services shall be delivered without regard to the ability of the client to pay for such services and without regard to the current or past condition of the individual with HIV disease.
- All providers of health care services are informed of the HIV status of any referred clients to ensure appropriate planning for the continuity of care.
- Funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item of service under any, state compensation program; insurance policy; federal or state health benefits program; or entity that provides health services on a prepaid basis verifying that Ryan White Part B is the payer of last resort.
- The subcontractor may not utilize funds to make direct or indirect payments to intended recipients of services or the families of recipients of services.

Service Delivery Area, Lead Applicants and WICY

Non-profit organizations are eligible to submit proposals in accordance with this RFP. The service delivery area is the entire state of Rhode Island, New Bedford and Fall River [as declared by HRSA's designation of our state's Metropolitan Statistical Area (MSA)]. Applicants must demonstrate that they will only serve clients who are eligible for Ryan White Part B-funded services.

A single organization must be the lead applicant. However, EOHHS welcomes collaboration and cooperation among organizations proposing to provide services. The lead applicant's proposal must document and describe collaborative efforts through the inclusion of formal written agreements with collaborative organizations with the application.

Non-profit organizations are prohibited from serving as conduits that pass on their awards to for-profit corporations. Federal grants management policy is clear that the eligibility requirements that apply to first-level entities cannot be evaded by passing awards through

second or sub-level entities that could not have received the award in the original competition. Rhode Island's HIV Part B care system is required by HRSA to meet a goal that for each population of women, infants, children, and youth, no less than the percentage of each population of women, infants, children, and youth with HIV/AIDS served by Rhode Island's HIV Part B care system to the general population of women, infants, children, and youth with HIV/AIDS in Rhode Island.

Specifically, no less than 31% of the clients served by Rhode Island's HIV Part B care system must be women (25 years of age and older), youth (13-24 years of age), children (2-12 years of age), and infants (less than two years of age). (See Attachment J Table and J.i 2013 WICY chart).

SECTION 3: SCOPE OF WORK

General Scope of Work

This section refers to the scope expected from each successful applicant. It is important to review and address each subsequent area in the applicant's proposal.

Addressing the Needs and Filling the Gaps in the Current System of HIV Care

Ryan White Part B funds target PLWH/As who do not have sufficient healthcare coverage or financial resources for coping with HIV disease by addressing needs and filling in gaps in care not covered by these other sources. As a result, EOHHS will award funds to applicants that demonstrate an ability to contribute to the creation and maintenance of a statewide HIV care infrastructure.

The primary goal associated with the scope of work for each applicant is to address needs/gaps and to meet those gaps and needs within your proposal and within the existing systems of HIV care; to ensure quality oriented, comprehensive, coordinated and responsive care.

Further, Rhode Island seeks to maintain and improve the health of all PLWH/A in the state. While doing so HRSA is clear that the services are to be payer of last resort, cost effective, and quality oriented. We seek applicants that shall maximize productivity for each awarded Ryan White dollar within federal and state contracting limits. This concept is to be further explored and determined as the Affordable Care Act rolls out. Funded Ryan White providers must be aware of the changing landscape and clearly determine their role in this new healthcare environment.

The goal of this RFP is to assure that, Rhode Island's Ryan White Part B funds reach the populations they have been charged to reach (those disproportionately impacted by HIV disease, the underinsured, uninsured and undocumented; the poor; ethnic and racial minorities; women: and people of all ages), by identifying those unaware of their status, enrolling PLWH/A in care, keeping them in care, paying for essential services, and reaching people other payers do not. EOHHS encourages the design of proposals, which aim to achieve "100% access and 0% disparity" with respect to the provision of comprehensive HIV core medical and support services for PLWH/A in Rhode Island.

To that end, each applicant must understand the current system of HIV care within the state and create specific outreach, recruitment and maintenance components that directly and positively affect PLWH/A.

Contractor Responsibilities

The contractors selected as a result of this RFP will:

- Be responsible to the Administrator and HIV Provision of Care staff of the Rhode Island Executive Office of Health & Human Services.
- Identify a Project Director as well as an HIV Quality Management Liaison, a Monitoring Standards/Reporting specialist, a Data Manager, a Fiscal contact and other appropriate field staff to support the tasks outlined in the RFP and the designated contract to successful applicants. Dependent upon the scope of work, one person may assume more than one role.
- Provide administrative support sufficient to carry out the tasks under this contract.
- Provide office space, equipment, utilities, and supplies necessary for the management of the project. The Contractor must be located in the State of Rhode Island.
- The Contractor shall supply its own computers, printers, and basic Microsoft Office software. The Contractor is responsible for any special software required for tasks related to the scope of work.
- In accordance with EOHHS requirements, develop, maintain, and enhance a quality management program consistent with HRSA requirements that includes standards of care and performance measures developed by EOHHS and serves to identify needs and gaps in services as well as in helping to ensure the delivery of quality services to clients.
- Develop and implement a strategy for assessing the needs of their clients annually (e.g. simple client needs assessment or client service satisfaction surveys) and share the results of completed assessments, or portions thereof, with EOHHS for the purpose of inclusion as a part of the EOHHS's comprehensive Ryan White Part B needs assessment. Agencies are always encouraged to address HIV care system gaps for PLWHAs and compare and contrast these to the needs that clients exhibit.
- In accordance with EOHHS's requirements, comply with all required project reporting requirements; including data reports, annual WICY report, annual RSR, Monitoring Standards, QM Standards of Care and QM Performance Measures.
- Collaborate with EOHHS to develop, implement, and enhance data systems that will allow for the accurate collection and reporting of program data.
- Submit monthly invoices utilizing EOHHS approved invoice forms by the 10th of each month.
- Appoint appropriate staff to serve on the Ryan White HIV Care Program's Provision of Care Planning Body (PCPB) and its associated subcommittees, including, but not limited to the Quality Management Committee, groups

focused on quality management, needs assessment, comprehensive planning, coordinated statement of needs, quality management, systems of care, and RSR reporting activities.

- Allow a team authorized by EOHHS to periodically conduct comprehensive site reviews to assure that contractors conform to existing federal Office of Management & Budget (OMB) requirements and federal and state Ryan White Part B program Monitoring Standards and requirements, and to take corrective actions if contracted services are found not to be in compliance with these requirements
- Serve each client without regard to the client's age, gender, local residency, or citizenship status.
- Collect and report gross program income earned by the vendor under a grant directly generated by grant-supported activity or earned as a result of the award consistent with federal grant requirements.
- Conduct and submit to EOHHS audits, using auditors meeting established criteria for qualifications and independence, in accordance with federal OMB requirements.
- Provide a documented and verifiable 10% match in non-federal revenue sources.
- Inform EOHHS immediately of any waiting lists or delays in providing Ryan White funded services to eligible PLWH/A.
- Comply with all federal and state monitoring standards and reporting requirements. The HRSA Ryan White Part B Monitoring Standards can be found at (<http://hab.hrsa.gov/manageyourgrant/files/programmonitoringpartb.pdf>) or on the EOHHS Ryan White RFP page at (<http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/Adults/RyanWhiteHIVCareProgram/RequestforProposals.aspx>).
- Adherence to NHAS, Equity, Early Identification of Individuals Living with HIV/AIDS (EIIHA) and Healthy People 2020 by creating strategies or plans that outline specific methods associated with agency support of the NHAS, equity, HP 2020 and goals associated with these national endeavors.
- Data, information, analysis, reports or publications prepared by the Contractor as part of the scope of work shall be deemed to be the property of the State. Any equipment purchased and paid for by the State under this contract, if any, shall be considered Rhode Island State property.
- The contractor will work under the direction of the EOHHS-designated Project Director.

Cultural Competence

Within the scope of work applicants must reveal and insure they are able to approach diverse populations in a culturally competent and effective manner. Rhode Island's Ryan White Part B funds target PLWH/A living throughout the Metropolitan Statistical Area (MSA) – a racially, ethnically, culturally and linguistically diverse population – and since HIV/AIDS infection has had a devastating impact on low-income persons, women, and

racial and ethnic minority populations the selected contractors must demonstrate cultural and linguistic competence.

The U.S. Health Resources and Services Administration (HRSA) defines cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural and linguistically diverse situations”.

National Standards for Culturally and Linguistically appropriate Services (CLAS) in Health Care mandates, guidelines, and recommendations issued by the U.S. Department of Health & Human Services, Office of Minority Health are intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health care services. CLAS mandates are current federal requirements for all recipients of federal funds (<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlid=15>).

Towards the goal of creating culturally competent programs and policies within/between agencies, each applicant must address specific cultural competency criteria that prove your program is effectively meeting these requirements as part of the scope of work.

Quality Management

Contractors will be required to adhere to EOHHS’s Quality Management Program, which includes, but is not limited to, Standards of Care and Performance Measures developed by EOHHS for each service category funded through this RFP. In addition, the quality management performance measures must reflect the HIV continuum of care. A copy of EOHHS’s current draft Standards of Care for each allowable service category is included as Attachment H.i. Attachments H and H.i refer to QM data reporting tools. Performance Measures are clearly labeled, and all applicants must integrate these performance measures into their goals and objectives. The Performance Measures developed by EOHHS will be based on the most current federal HIV Performance Measures (See <http://hab.hrsa.gov/special/habmeasures.htm>) and input from key local stakeholders. The Performance Measures will comprise indicators that EOHHS will use in monitoring the quality of care provided by its contractors. EOHHS will select Performance Measures that are most important to Rhode Island and the HIV populations it serves. Contractors will be required to submit quality management reports to EOHHS in accordance with federal and state requirements.

As part of the scope of work all applicants/vendors must have a clearly written quality management plan with associative standards of care and performance measures in accordance with the HRSA guidelines. Each agency must also designate one staff member that is affiliated with the Ryan White contract, as a HIV Quality Management Liaison and that person or designee must serve on the Rhode Island HIV Quality Management Committee and designate a staff person within the body of your proposal.

Specific Activities / Tasks

Contractors awarded funds under this RFP will be required to:

1. Report Ryan White HIV/AIDS Program Services Reports (RSR) in accordance with federal and state requirements. For additional information about HRSA's RSR reporting requirements, see <http://hab.hrsa.gov/manage/CLD.htm>.

2. Contractors will be required to have data systems that are transferrable and complimentary to CAREWare software. They also have the option of utilizing CAREWare within their agencies and reporting directly via this system. CAREWare is free software for managing and monitoring HIV clinical and supportive care, which quickly produces a completed Ryan White HIV/AIDS Program Services Report (RSR). For additional information about CAREWare, see <http://hab.hrsa.gov/CAREWare/>. **If you are currently a funded agency and do not have the internal capabilities of transferring data into CAREWare (exporting data to the EOHHS) your proposal may be disqualified.** Funded service providers will be required to complete a Service Provider Report to HRSA on-line. In addition to providing some basic information about their organization, providers, in collaboration with EOHHS, will be required to view a list of Ryan White Program services and check the boxes next to all services that their organization delivered to Ryan White Part B clients during the reporting period. In addition, service providers will be required to submit a Client Report on-line as an electronic file upload using a standard format. Each upload file will contain one record per client. Each client record will include information on demographic status, HIV clinical information, HIV-care medical and support services received, and the client's "UCI", an encrypted, unique client identifier.

3. Contractors will be required to document gaps and needs within their scope of programming and activities. In addition to sharing specific needs assessments performed by the applicant, approved applicants must participate in needs assessment, comprehensive planning, and coordinated statement of needs activities in accordance with federal and state requirements. *These activities involve a process of collecting information about the need for services among PLWH/A (both those receiving care and those not in care).* The information is analyzed to identify what services are needed in Rhode Island. Results from the needs assessment will be utilized to set priorities for the allocation of resources, developing a statewide comprehensive plan and coordinated statement of need. Participation in this process will include but not be limited to, participating in meetings, working with EOHHS to coordinate provider and/or client survey and/or focus groups activities involving contractor staff and clients, and implementing and sharing the results of any internal needs assessment data and/or survey information pertaining to client needs, gaps, and service priorities with EOHHS. *Applicants must have a firm understanding of the needs and gaps within the targeted populations they serve. To that end, the state has done extensive analysis on needs and gaps and these assessments and analyses are shared herein. Agencies applying for these funds must reveal agency specific and/or other agency population data that reflect needs/gaps. Each agency applying for funds must submit accurate and detailed needs assessment and gaps data based upon the services provided under Ryan White, and other services for people living with HIV/AIDS. Failure to do so may disqualify the applicant's proposal.*

4. Contractors must incorporate the HRSA|HAB monitoring standards in all aspects of their proposals.

Needs Assessment Data

2012 State Results General Prioritization Survey (Internet-Based)

1. ADAP
2. Outpatient ambulatory care
3. Medical case management
4. Non-medical case management
5. Emergency financial assistance/substance abuse services.
6. Health insurance premiums/COBRA benefit
7. Mental health services
8. Psychosocial services
9. Medical transportation
10. Hospice services
11. Oral health services
12. Medical nutritional therapy
13. Short term housing
14. Food bank/delivered meals
15. Home and community based services

Other open ended responses included single answers for “more outreach,” “more testing,” “education and prevention,” “permanent housing,” “peer outreach,” “vitamins covered under ADAP,” “medication adherence,” “long term financial assistance,” “clothing,” “hygienic supplies,” and “legal assistance.” ***The table below depicts results of the formal prioritization exercise held on 7 June 2012 (see next page):***

TABLE 1	7 June 2012 Prioritization Exercise
Service Categories	
<p>Core Medical Services – Direct provision of essential, direct health care services specified in the RW Modernization Act that maintain or improve HIV-clinical related health outcomes.</p>	<ul style="list-style-type: none"> ❖ ADAP: The workgroup felt that this program was a top priority and should be held sacrosanct. ADAP received a #1 weight and a #1 priority ranking. ❖ Outpatient/ambulatory medical care: #1 weight. ❖ Health insurance premium and cost sharing assistance/COBRA: #1 weight ❖ Home and Community Base Health Services Received: #3 weight ❖ Medical nutrition therapy : #3 weight ❖ Substance abuse/mental health services: #1 (the group wished to have them placed together). NOTE: The state has decided not to include substance abuse funds in this RFP due to the availability of substance abuse services within the state and state substance abuse treatment services list PLWH/As as a priority population for access to these services. ❖ Medical Case Management #1
<p>Support Services – Services that are essential to achieving positive medical outcomes that affect the HIV-related clinical status of PLWH/As.</p>	<ul style="list-style-type: none"> ❖ Non-Medical Case Management: #1 ❖ Emergency Financial Assistance: #3 NOTE: The individuals participating in the forum noted that although emergency relief services are important often times the low cap on these service does not really assist PLWH/A with needs like one month rent payment. Participants in the assessment process said while important the current system isn't really helping so they recommended increasing the cap for this purpose. With that said if the cap is increased less people will be served. We have therefore increased the cap from \$200 per client/per year to \$400 per client per year. ❖ Food Bank/Hot Meals Delivery: Participants noted that if these services are available in the state then Ryan White should be a secondary consideration for paying for these. #2 ❖ Med. Transportation: #2 ❖ Psychosocial Support: #2
<p>Note regarding access to care, availability of health services and retention – The workgroup felt that these all needed some understanding within the state as they prioritized. What follows are areas participants felt were related to access, availability and retention in care.</p> <p>No weights were given here as they may be related to a funded service and are already listed above. However, if funding is available these were deemed important enough to consider in the next RFP.</p> <ul style="list-style-type: none"> ❖ Enhanced healthcare coverage for PLWH/A : RW service to promote in RI is health insurance premium. Note that the Affordable care Act will enhance healthcare insurance for PLWH/As in the state. ❖ Food bank/home-delivered meals: Workgroup members noted that this provides an essential HIV related food/nutrition program that does not exist widely for PLWH/As and these services help people keep healthy and stay in care. ❖ Promote stable housing: RW services to promote home and community health services: specifically looking at home based services as a continuing Assisted Living Facility option. ❖ Health Insurance Premiums: necessary and needed as we navigate thru the healthcare system payer issues. ❖ Consumer Picks: legal services, peer to peer education (so as to enhance prevention), and medical treatment/medication, and vitamins 	

Note that some of the suggested services in the aforementioned assessment may not appear as options in this RFP. If the state has services in place and is utilizing other resources to provide these services (e.g., substance abuse services in RI are available to PLWH/A as a priority sub-group, therefore the decision not to fund substance abuse services within this RFP was made). In addition, policies and recommendations from HRSA, and a review of services available through other public and private entities in Rhode Island were also taken into consideration. Based on this process, the list of core services for Rhode Island included in this RFP were identified from the list of definitions for eligible services under the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and subsequent 2009 reauthorization. Vendors must adhere to the HRSA defined services as written (see #7 below).

5. Contractors awarded funds through this RFP must present a quality management plan and establish a quality management program that are consistent with the most recent Public Health Services guidelines for the treatment of HIV/AIDS and related opportunistic infections and, as applicable, to develop strategies for ensuring that services are consistent with the guidelines for improvements in the access and quality of HIV services. The quality management program must be approved by EOHHS prior to implementation. *If you are a currently funded agency and do not have a Quality Management Plan for your agency devoted exclusively to the Standards of Care in the state HIV QM Plan, your proposal may be disqualified.* Quality management services are a systematic process with identified leadership, accountability, and dedicated resources that use data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. Quality management programs should focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement, and need to be adaptive to change.

Quality management is a continuous process to improve the degree to which a health or social service meets or exceeds established professional standards and user expectations. The purpose of a quality management program is to ensure that: (a) services adhere to PHS guidelines and established clinical practice; (b) program improvements include supportive services; (c) supportive services are linked to access and adherence to medical care; and (d) demographic, clinical, and utilization data are used to evaluate and address characteristics of the local epidemic. (For further information on quality management of the federal Ryan White HIV/AIDS Program, refer to the Technical Assistance Manual available at <http://hab.hrsa.gov/tools/QM/index.htm>.)

6. Contractors are also expected to develop and implement a brief written public awareness plan with a strong evaluation component for ensuring that eligible PLWH/A in Rhode Island are made aware of the availability of Ryan White funded services. The public awareness plan must be approved by EOHHS.

7. As part of the scope of work and noted activities, applicants must select from the following “Definitions for Eligible Services Under Rhode Island’s Ryan White HIV Care Part B Program” (See Attachment F regarding HRSA allowable service category descriptions under Ryan White. Note that RI has chosen to fund some of these, not all. The applicant is to use this document as a guide to understand the definitions within this RFP that the state selected to fund.)

These definitions, which are based on the federal HIV/AIDS Bureau’s list of definitions for eligible services (August 14, 2010), updated Policy Notice 10-02 describing the allowable uses of Ryan White HIV/AIDS Program funds for defined categories for eligible individuals (April 8, 2010) and Policy Notice 07-04 regarding the use of Ryan White funds for transitional support and primary care services for incarcerated persons (September 28, 2007), have been tailored to meet Rhode Island’s specific needs. Applicants that wish to provide oral health care, health insurance premium assistance, mental health services, medical nutrition therapy, emergency financial assistance, food bank/home delivered meals, medical transportation, and psycho-social support services must also provide non-medical or medical case management services. To be specific, all of these aforementioned support services shall wrap around case management.

7. a. Core Medical Services

Core medical services are a set of essential, direct health care services provided to PLWH/A and specified in the Ryan White HIV/AIDS Treatment Modernization Act. As mentioned above the state must invest at least 75% of Ryan White resources for this purpose.

7.a.i. Outpatient/ambulatory medical 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 include 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 Service's (PHS's) guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Individuals who receive Ryan White funded outpatient/ambulatory health care services must have no source of healthcare or have public or private insurance that does not meet their outpatient/ambulatory medical care needs. Funding for this service category will be through line-item reimbursement. Agencies awarded funds to provide outpatient/ambulatory health care services must accept referrals from other Ryan White funded agencies that do not provide such services.

7.a.ii. Oral Health care includes diagnostic, preventive, and therapeutic services provided by general dentists, dental specialists, dental hygienists and auxiliaries, and other trained oral health care providers. Individuals who receive Ryan White funded oral health care services must have no source of health care or have public or private insurance that does not meet their oral health care needs. In Rhode Island our goal is to focus upon preventive care, and when absolutely necessary, therapeutic services when no other payer is available.

EOHHS will consider applicants that have solicited oral health insurance costs from reputable agents as part of this proposal. Applicants may use HealthSourceRI as a resource for such costs associated with oral health insurance. Specifically, agencies that provide us with estimates of oral health insurance that match or are below the cap of \$1,500 per year per client, will be highly desirable. In this scenario clients will select a dental plan and the applicant will pay the insurer. The successful applicant in this case shall be the payer to the insurer and no clients shall receive direct monies. In this scenario the likelihood of providing a comprehensive array of dental services is increased whereby preventive and therapeutic services will be possible.

Organizations awarded funds under this category must develop and implement an outreach plan, with a strong evaluation component, that is designed to maximize the number of eligible clients who access oral health care benefits. Agencies awarded funds under this category must accept referrals from Ryan White funded agencies that do not provide such services.

7.a.iii. Health insurance premium assistance is the provision of financial assistance through premium payments for eligible PLWHA living with HIV to maintain a continuity of health insurance or to receive medical benefits under an individual health insurance program. Premiums to support family plans are prohibited. Eligible individuals include PLWHA who were covered, but who are no longer covered, by an employer-based health plan (the individual may have become unemployed or their employer no longer offers health insurance coverage to its employees), PLWHA whose employer does not offer health insurance coverage to its employees, and PLWHA who are small business owners who cannot afford health insurance.

We are only soliciting applicants that can administer COBRA benefits only. The state shall run and monitor the premium assistance program. The purpose of the assistance is to

maintain uninterrupted access to health care for eligible individuals until they qualify for Medicare, Medicaid, other employer-based health care, or until their COBRA eligibility expires.

The contractor selected for COBRA benefits must ensure that no interruption in client coverage occurs by meeting 100% of all health insurance premium payment deadlines. Agencies awarded funds to provide COBRA health insurance premium assistance must accept referrals from other Ryan White funded agencies that do not provide such services. Clients receiving health insurance premium assistance must be referred to ADAP for possible assistance with medication co-payments. Agencies applying for the COBRA benefit must also apply for and be successful in receiving funds for non-medical or medical case management services so as to create and effective use of these funds.

7.a.iv. Home and community-based Health services includes skilled health services furnished to the individual in the individual's home, based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include: treatment (including medication) adherence, durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospital services, nursing homes, and other long-term care facilities are not included as home and community-based health services. ***In order to qualify as a Ryan White home and community-based health care agency providing residential services, an agency must provide comprehensive therapeutic nursing and supportive health services care to clients and have Rhode Island Assisted Living Care Facility licensure. An agency may propose to offer in-home care options, and they must prove cost effectiveness associated with the services they provide. The state is interested in minimizing costs associated with hospital emergency department visits, hospitalizations, and long term care stays. In short, if an agency can prove diversion of these high cost items via home and community based health services, they will be highly desirable. To that end, the provision of data associated with how this will occur, and your agency specific experience/data in diverting these high cost endpoints is requested.***

To be eligible for a **residential home and community based service**, clients must have a history of incarceration, substance abuse and/or mental health problems and meet the guidelines for home and community-based health services annually. It is expected that all other sources of funding in the community for home and community-based health care (including opportunities presented through healthcare reform) will be effectively pursued and utilized and that any allocation of Ryan White funds for these purposes will be the payer of last resort. Agencies awarded funds to provide home and community-based health care services must accept referrals from other Ryan White funded agencies that do not provide such services. Funding for this service category will be through line-item reimbursement.

7.a.v. Mental Health services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting, and provided by a mental health professional licensed or

authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers. The goal of this funding is to support PLWH/A to maintain treatment adherence by improving their mental health through the provision of mental health and/or dual mental health/substance abuse counseling and care coordination between the funded agency and the client's primary care provider. Substance abuse counseling services provided to eligible PLWH/A who do not have a mental health diagnosis is not allowable under this service category. Individuals who receive Ryan White funded mental health services must have no source of healthcare or have public or private insurance that does not meet their mental healthcare needs. It is expected that all other sources of funding in the community for mental health services will be effectively utilized and that any allocation of Ryan White funds for these purposes will be the payer of last resort. Agencies awarded funds to provide mental health services must accept referrals from other Ryan White funded agencies that do not provide such services. Funding for this service category will be through line-item reimbursement. Agencies that offer an innovative solution to the needs, barriers and gaps in the present mental health system will be desirable for administering this service.

7.a.vi. Medical nutrition therapy (MNT), including nutritional counseling and nutritional supplements, provided by a licensed registered dietitian outside of a primary care visit is an allowable core medical service under the Ryan White HIV/AIDS Program. Nutritional services not provided by a licensed, registered dietician is considered to be a support service under the Ryan White HIV/AIDS Program. Individuals who receive Ryan White funded medical nutrition therapy must have no source of health care or have public or private insurance that does not meet their medical nutrition therapy needs.

The provision of nutritional supplements must address unintentional weight loss and malnutrition in an individual caused by decreased intake of food, medication side effects, decreased absorption of nutrients, untreated secondary infection, or alterations in metabolism. It is not acceptable to provide nutritional supplements to individuals to address economic and social conditions, including the lack of knowledge about good nutrition, the inability to prepare meals, or not having enough money to purchase food (these individuals should be referred to nutritional counseling, Meals on Wheels, the Supplemental Nutrition Assistance Program (SNAP), a local Food Bank/Food Pantry or other local nutrition/food assistance program). A clinician must provide documentation that the MNT is medically necessary. The maximum amount of nutritional supplements provided to each individual shall be no more than three cans per day or the equivalent amount in other forms (e.g. powders, bars, etc.). Clients receiving nutritional supplements must have a written nutritional management plan, which would include nutritional counseling, designed by a licensed dietician to help the client stop the weight loss and regain lost weight and lost Lean Body Mass (LBM) or Body Cell Mass (BCM) through primarily food and the management of medical symptoms, such as nausea, diarrhea, and vomiting. The dietician must forward a copy of the plan and subsequent progress reports to the client's physician. The physician will determine the progress report schedule. Agencies awarded funds to provide medical nutrition therapy services must accept referrals from other Ryan White funded agencies that do not provide such services. Funding for services provided by the dietician and the nutritional supplements will be provided through line-item reimbursement. Agencies applying for this service must also apply for and be successful in receiving

funds for non-medical or medical case management services so as to create and effective use of these funds.

7a.vii. Medical case management and/or Transitional medical case management services (including treatment adherence and referral for healthcare/supportive services) for incarcerated persons as they prepare to exit the correctional system as part of effective discharge planning or when they are in the correctional system for a brief period, which would not include any discharge planning. An incarcerated person refers to an individual involuntarily confined in associated with an allegation of finding of behavior that is subject to criminal prosecution. This service category applies to individuals who are involuntarily living in the secure custody of law enforcement, judicial, or penal authorities and individuals who reside in a community setting (which is not part of the institutional setting of the prison system such as a pre-release residential half-way house) if the individuals is still involuntarily confined to those settings.

7a.viii. Medical case management may also be provided as a service that is broader than the transitional population described above, and is incorporated into a medical/clinical setting. Specifically, clinical providers may propose medical case management programming for PLWH/A that incorporates all of the HRSA allowable components for this service.

If an applicant chooses to apply for medical case management (without transitional services) the setting must fit with the definition herein and must adhere to the delivery requirements associated with medical case management.

The intent of all Ryan White Program funds is to ensure that all eligible PLWH/A gain or maintain access to HIV-related care and treatment. This service category recognizes that many incarcerated PLWH/A will ultimately be the responsibility of the Ryan White HIV/AIDS Program, so early detection, entry into care, and access to and continuity of care are important reasons to use Ryan White funds for incarcerated individuals who meet the qualifications outlined above. Federal policy provides for the use of transitional medical case management to help achieve immediate linkages to community-based care and outpatient/ambulatory health care services upon release from custody, where no other services exist, or where these services are **NOT** the responsibility of the correctional system.

The services provided through this funding must supplement, but not supplant, existing programs and responsibilities administered by the correctional system or other federal, state, or local agencies. Federal policy does not generally permit the use of Ryan White funds in federal and state prison facilities, since federal and state prison systems are responsible for providing health care services to all individuals remanded to the facility. Such care is the responsibility of law enforcement, judicial, and penal authorities in whose secure custody the individual is held. This limitation, however, does not apply to federal and state inmates who are about to be released to the community and who are receiving health-related services using community resources, when not actually living in the correctional facility, such as home detention and half-way house programs. Proposals must include an assessment to the extent to which services are or should be covered. The

applicant must delineate precisely what services will be provided by the applicant, if awarded, and by the correctional system.

The medical case management services provided under this service category must be provided by trained professionals, including both medically credentialed and other healthcare staff who provide a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through an ongoing assessment/reassessment of the client and other key family members' needs and personal support systems.

Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized care plan; (3) coordination of services required to implement the plan; (4) continuous client monitoring to assess the efficacy of the care plan; and (5) periodic reevaluation and adaptation of the care plan, at least every six months, as necessary during the enrollment of the client.

Referral for healthcare/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Funds awarded under medical case management must also be used to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, AIDS Drug Assistance Program (ADAP), Pharmaceutical Manufacturer's Patient Assistance Programs (PAPS), and other state and local health care and supportive services).

A key component of medical case management are services that have as their principal purpose identification of individuals who know their HIV status but who have dropped out of care and treatment services, including ADAP, so that they may be re-enrolled in such services by the medical case manager. The allowable timeframe for the provision of transitional medical case management services for incarcerated PLWH/A must not exceed 180 days. Funding for this service category will be through line-item reimbursement. Applicants must also provide a specific "prevention" plan, procedure, protocol or strategy that reveals how case managers are trained in HIV/STI prevention and incorporate HIV/STI prevention into the client care plan and into each visit.

b. Support Services

Support services are a set of services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV/AIDS.

7.b.i. Non-Medicaid, Non-medical case management services (including referral for healthcare/supportive services) include the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments. Referral for health care/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Individuals who receive Ryan

White funded non-medical services must have no source of EOHHS care or have public or private insurance that does not meet their non-medical case management needs.

Funds awarded under non-medical case management must also be used to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, AIDS Drug Assistance Program (ADAP), Pharmaceutical Manufacturer's Patient Assistance Programs (PAPS), and other state and local EOHHS care and supportive services). Contractors providing non-medical case management services under this RFP must adhere to EOHHS's current scope of work for non-medical case management services (See Attachment G). EOHHS reserves the right to revise the scope or work for non-medical case management services in response to changing client needs and new state or federal requirements.

A key component of non-medical case management are services that have as their principal purpose identification of individuals who know their HIV status but who have dropped out of care and treatment services, including ADAP, so that they may be re-enrolled in such services by the non-medical case manager. To that end, agencies applying for this category must assert a specific plan for working with clients who know their HIV status but who have dropped out of care and treatment services, including ADAP, so that they may be re-enrolled in such services.

Reimbursement for Ryan White services regarding non-medical (Non-Medicaid) case management will be through line-item reimbursement. ***This is noted as a change from the past practice of the state, which allowed for a unit cost structure.*** For non-Medicaid case management clients, applicants must create a budget that is based upon salary, and line items pertaining to the execution of the service. Applicants must be clear, have adequate back up, and state the time and effort associated with each client when asking for reimbursement. Agencies applying for this category of service must illustrate how they will account for the funds associated with this program as they relate to Part B clients. Agencies must also describe in detail the severity/acuity index they apply to clients and the number of clients they service that fall into the severity/acuity index categories (e.g., low, medium, high).

In order to be accepted and approved as a non-medical case management organization the vendor must be a Medicaid provider. Applicants must also provide a specific "prevention" plan, procedure, protocol or strategy that reveals how case managers are trained in HIV/STI prevention and incorporate HIV/STI prevention into the client care plan and into each visit.

7.b.ii. Emergency financial assistance is the provision of short-term payments to agencies to assist with emergency expenses related to medical transportation, essential utilities, housing (specifically, rental payments), and prescription assistance when other resources are not available. Agencies deliberately and clearly must set priorities and delineate and monitor what part of the overall allocation for emergency financial assistance is obligated for each allowable category (medical transportation, essential utilities, rental payments, and prescription assistance). Careful monitoring of expenditures within a category of

“emergency financial assistance” is necessary to ensure that planned amounts for specific services are being implemented, and to indicate when reallocations may be necessary.

In addition, agencies must develop standard limitations on the provision of funded emergency financial assistance to eligible individuals/households and mandate their consistent application. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively utilized and that any allocation of Ryan White funds for these purposes will be the payer of last resort, and for limited amounts, limited use, and limited periods of time. Agencies awarded funds to provide emergency financial services must accept referrals from other Ryan White funded agencies that do not provide such services. Agencies applying for this service must also apply for and be successful in receiving funds for non-medical or medical case management services so as to create effective use of these funds.

The provision of emergency financial assistance will be limited to a total of \$400 per client per year regardless of the type of emergency assistance provided (essential utilities, rental payments, and non-ADAP prescription assistance). EOHHS reserves the right to modify this limit at any time based on emerging needs assessment data, client utilization patterns, the state of the economy, and other considerations. Agencies applying for this service must outline the specific eligibility requirements for clients and specify any funding that may augment this service. Agencies applying for this service must also apply for and be successful in receiving funds for non-medical or medical case management services so as to create effective use and dispersion of these services.

7.b.iii. Food bank/home-delivered meals are the provision of actual food or meals. It does not include finances provided directly to the client to purchase food or meals, but may include limited vouchers to purchase food. It is expected that all other sources of funding in the community for emergency food bank/home-delivered meals will be effectively utilized and that any allocation of Ryan White funds for these purposes will be the payer of last resort. Agencies applying for this service must outline the specific eligibility requirements for clients and specify any funding that may augment this service. Agencies awarded funds to provide food bank/home-delivered meals must accept referrals from other Ryan White funded agencies that do not provide such services. Agencies applying for this service must be also apply for and be successful in receiving funds for non-medical or medical case management services so as to create effective use of these funds.

7.b.iv. Medical transportation is an allowable support service under Ryan White. Funds may be used to provide transportation services for an eligible individual to access HIV-related health services, including services needed to maintain the client in HIV/AIDS medical care. Individuals who receive Ryan White funded medical transportation services must have no source of health care or have public or private insurance that does not meet their medical transportation needs. Agencies awarded funds to provide medical transportation services must accept referrals from other Ryan White funded agencies that do not provide such services. Funding for medical transportation services will be provided through line-item reimbursement. Agencies applying for this service must also apply for and be successful in, receiving funds for non-medical or medical case management services so as to create and effective use of these funds. Agencies applying for this service must outline the specific eligibility requirements for clients and specify any funding that may augment

this service. Applicants must review options that are most cost effective (e.g. RIPTIX yearly versus individual passes) and discuss those options within their proposal.

7.b.v. Psychosocial support services are the provision of support and counseling activities and HIV support groups. It also may include nutrition counseling provided by a non-licensed dietitian, but it excludes the provision of nutritional supplements. Individuals who receive Ryan White funded psychosocial support services must have no source of EOHHS care or have public or private insurance that does not meet their psychosocial support service needs. Agencies applying for this service must outline the specific eligibility requirements for clients and specify any funding that may augment this service. Agencies awarded funds to provide psychosocial support services must accept referrals from other Ryan White funded agencies that do not provide such services. Funding for psychosocial support services will be provided through line-item reimbursement.

SECTION 4: TECHNICAL PROPOSAL

Narrative and format: The separate technical proposal should address specifically each of the required elements:

Part I: Cover Page/Letter & Table of Contents

The Cover Page and Letter (See Attachment A for Cover Page Form) must be completed and included as a part of the application. Note that if you are applying for more than one service category you must clearly state those in the cover letter. The individual(s) authorized to sign on behalf of the applicant organization or in the case of applicants applying for oral health care services, a licensed dentist, must sign this page. As noted previously, the cover page must be included as the first page of the application. A Table of Contents must follow the Cover Letter. Limit this section to two pages; one for the letter and one for the cover page form. There is no limit to the Table of Contents.

Part II: Project Narrative

The information contained in the Project Narrative section constitutes a bulk of the proposal. Requested supporting documentation must be included as appendices. The Project Narrative must be presented in accordance with the following format:

II.A. Introduction

Please describe to the reviewers what you plan to accomplish and outline the parameters of the content of your intent and proposal.

II.B. Needs Assessment

The applicant must provide the following information:

- A geographic description of the service area with regard to communities affected by HIV/AIDS. Discuss seasonal or topographic factors if they impact

the availability of and accessibility to Ryan White service categories for which funding is requested. If you are to extend beyond state lines into the MSA designated areas of New Bedford and Fall River clearly describe the outreach and the physical ability of the agency to be in these areas (e.g., We have an office in New Bedford, We have a mobile van that shall be located on X Street in Fall River, We have outreach workers in Fall River and New Bedford designated for the purposes of X...etc.).

- A demographic description of the service area and populations proposed to be served. Demographic statistics should be included if the information impacts access to or delivery of Ryan White services categories for which funding is requested. Examples of data presented could include, but not be limited to, health disparities, including race/ethnicity, and special populations.
- Estimated numbers and percentages of women, youth, children, and infants to be served (See **Attachment J and J.i**).
- A description of the needs and gaps of the eligible PLWH/A to be served that experience disparities in access to the core medical and/or support service categories for which funds are requested. Agencies that have received funding in the past must reveal data from assessments and or specific data they have accumulated under their Ryan White funding time span. Agencies not currently funded with Ryan White resources must also have definitive assessments that display need and/or gaps of the populations they intend to serve. Applicants may append assessments if they cannot be adequately summarized in this section. The reviewer's shall be looking at specific data that reveals needs/gaps, an analysis of that data and integration of the needs/gaps assessments with the proposal (e.g., Based on this data and the needs/gaps described herein, agency X can meet these needs/gaps in the following manner...).

II.C. Populations To Be Served/Continuum of Care Described

- Describe any high priority populations and/or target area to be served. Describe equity issues and incorporate equity strategies that meet the populations you mention. Target populations include minorities, MSM, transgendered individuals, women, infants, children and youth (WICY) as described by Rhode Island's epidemiology.
- A description of the continuum of care offered by the applicant, including how clients are supported in accessing and remaining in care. Follow the NHAS here and designate goals that compliment NHAS as well as specific strategies as to how your agency and this proposal will isolate people out of care, keep them in care and support prevention activities associated with decreasing incidence.
- Reference to the treatment cascade/HIV continuum of care must be included with reference to how the agency is currently meeting these cascade outcomes.

II.D. Applicant's Selected Service Category(s) and Operational Description of The Program(s)

- A description of existing resources for the provision of service categories for which funding is requested.
- Description of any fee schedules and/or restrictions (such as waiting lists, cost-shares, or co-pays, etc.).
- A description of statewide or community resources and networks related to HIV care, including inter- and intra- agency linkages. Describe the relationship with these organizations. Describe how the agency will work with other agencies within a comprehensive system of care framework and minimize duplication of resources. Provide copies of formal agreements if applicable.

II.E. Applicant’s Strategies to Meet National Requirements, HRSA Requirements and State Requirements

- Clearly describe and provide proof of adherence to how the agency implements Ryan White “payer of last resort” requirements. The applicant will describe and append any procedures policies, etc. that describe how Part B dollars will be tracked and what specific policies are in place regarding screening and insuring payer of last resort.
- A description of how the agency will implement and share with EOHHS, for inclusion as a part of EOHHS’s needs assessment, comprehensive planning, and coordinated statement of needs process, any internal assessment data and/or survey information pertaining to agency client needs, gaps, and service priorities.
- A description regarding how the applicant will meet the aforementioned contractor responsibilities specifically outlining each area.

Identify sources of all data. This Project Narrative Section II.A. through II. E. outlined above should be no longer than 10 pages in length. The applicant must include a completed **Attachment J and J.i** (WICY) and place it in the Appendices section of the application. Copies of formal linkage agreements must also be included in Appendix I of the application.

Part III: Agency Qualifications & Experience

Minimum Vendor Requirements to Meet HRSA Requirements

The successful applicant(s) will have the requisite experience and resources to carry out the activities detailed in the scope of work section of this RFP that they propose to provide to eligible PLWH/A. Specifically, the successful applicant(s) must:

- Be a non-profit organization (designated a 501 (c) 3 organization by the Internal Revenue Service
- Have expertise providing medical care and/or support services to PLWH/A

- Description on the degree to which the applicant is qualified and experienced in providing core medical and/or support services to culturally diverse, low-income PLWH/A.
- Be Medicaid-certified if providing Medicaid-eligible services
- Demonstrate cultural and linguistic competence through clearly defined values, behaviors, attitudes, policies, structures and practices and compliance with, at a minimum, CLAS mandates
- A description of how the applicant will implement and monitor federally mandated CLAS requirements
- Provide a sufficient number of dedicated on-site and/or consulting staff with expertise and credentials to carry out funded activities
- Have the expertise to participate in quality management and needs assessment activities
- A description of similar projects undertaken and/or similar clients served, including a brief detailing of the projects that have tasks similar to those included in this RFP.
- A description of the applicant's process to track Ryan White funds, including information of the data systems used.
- A description of the process used for fiscal and program monitoring, including the frequency of reports.
- A description of the process for selection and rotation of board members.

This section (Part III) must not exceed six (6) pages in length. The applicant must include an organizational chart, evidence of non-profit status, a listing governing board and/or advisory board members that have identified expertise and populations represented, evidence of Medicaid certification (if the agency is providing Medicaid-eligible services), and, for home and community-based health care services in a residential setting, evidence of Rhode Island Assisted Living Facility licensure as Appendix II in the application. The organizational chart must depict the administrative structure responsible for the administration of the Part B grant. The applicant should also include an organization chart for fiscal staff, if fiscal staff is not within the proposed Ryan White project staff personnel.

Part IV: Work Plan Detailing Specific, Measurable, Achievable, Realistic and Time framed Goals and Objectives

The purpose of this section is to present the applicant's service plan, with specific attention to ensuring access to a continuum of HIV/AIDS care. The work plan is meant to be an ongoing monitoring and evaluation tool for the contractor and EOHHS. The Work Plan is a major component of the application.

The applicant must provide the following information for this section entitled Work Plan:

- A description of how the applicant's proposed project plan will reflect the intended purpose of Ryan White for the service categories for which funds are requested. This section should describe the applicant's understanding of federal and state Ryan White Part B requirements. Be certain to adhere to

the HRSA/Rhode Island definitions for the service areas you select and describe.

- Goals and objectives for the first year of the proposed 3-year project period for each of the service categories for which funds are requested. Goals are relatively broad and express a sense of a desired future state or direction. Goals should address identified needs. Objectives are descriptions of Specific, Measurable, Achievable, Realistic, Time-Framed (SMART) results or outcomes projected. They can be used to identify an acceptable level of performance and/or establish criteria for evaluation. A baseline, or starting point, for each objective should be included. Each Goal must have an associated series of objectives, and activities associated with the objectives.
- A description of the action steps that must occur to accomplish each objective – critical actions that must be taken to attain the measurable outcome or end result. Identify the kinds of data to be collected and maintained and the staff who will be responsible for oversight and/or performance for each objective.
- A description of the evaluation system for service categories for which funds are requested which must assess, at a minimum, the quality of care provided to clients, the success or failure in meeting goals and objectives, effectiveness in meeting identified needs of the targeted population, effectiveness and efficiency of program operations, and the process used to assess client satisfaction, the method for ensuring ongoing availability of effective and high quality services, and the process for resolution of identified quality issues. An evaluation statement at the end of each goal/objective section, must offer quantifiable endpoints within a specified timeframe as to how and when the goal/objectives will be achieved.
- A description of how the applicant's plan will reduce or eliminate service and health outcomes/disparities among populations with specific needs for services proposed to be funded. A description of how proposed Work Plan activities will provide increased access to the HIV continuum of care for minority communities and will meet the needs of any emerging populations.
- A description of how the agency will utilize all sources of funding available to it to work toward achieving health equity for PLWH/A populations, through eliminating health disparities and by preventing and controlling disease.
- A description of how the proposed Work Plan activities will ensure that PLWH/A remain engaged in HIV/AIDS primary medical care and adhere to HIV treatment.
- A description of how proposed Work Plan activities will address unmet need and reduce the number of PLWH/A out of care, keeping in mind that the needs assessment that EOHHS conducted indicated that a higher proportion of persons "not in care" are persons of color, born outside the United States of its territories, living with HIV not AIDS, and recently incarcerated.
- How the services and their goals and objectives relate to the goals of the national Healthy People 2020 initiatives (See www.Healthypeople.gov/ and <http://www.Healthypeople.gov/2010/default.htm>).

- How the plan will ensure that Ryan White funds will be cost effective, coordinated, and used as the payer of last resort for each service category for which funds are requested.
- Since HRSA has outlined a very specific monitoring strategy, agencies must clearly describe their strategy for meeting the monitoring requirements across program, fiscal areas. See Attachment E for the Monitoring Standards.
- Specific plans to submit RSR and comply with the RSR requirement.
- Specific plans to submit, utilize, and adhere to the QM Standards of Care and the Performance measures (see Attachment H.i)

This section (Part IV) must not exceed five (5) pages in length for each service category/HRSA definition (e.g., If an agency is applying for medical case management and mental health services then they may submit 10 pages here) for which funds are requested. The applicant must complete the Implementation Plan Table (See Attachment B) for the first-year of the 3-year project period and include it as a part of this application. The Implementation Plan Table can be used by the applicant as a way to visually present the applicant's proposed goals, objectives, and outcomes/indicators to be tracked as long as this decision is referenced, all other information requested above is including in the Work Plan narrative, and that it is clear to the reviewers what the proposed Work Plan strives to accomplish during the project period. A distinct and separate Implementation Plan must be completed for each service category for which funds are requested. Include the Implementation Plan as Appendix III in the application.

Five basic steps must be used to develop unit costs within the Implementation Plan: 1) Define the exact units of service (e.g., an office visit) , 2) count the total number of units in the given time period, 3) determine all the direct and indirect costs of producing the units of service, 4) add these components of full costs for the same time period, and 5) divide the full cost by the total number of service units to arrive at the average unit cost. The Implementation Plan Table must be placed as an Appendix within the application you submit.

Part V: Staffing Plan

The applicant must provide the following information:

- A description of the staffing plan that includes a detailing of the education, experience, qualifications, roles and responsibilities of each staff position (include both program and fiscal staff positions) dedicated to Ryan White Part B activities regardless of funding source.
- Identification of staff that are associated with key areas of programming; Project Manager/Supervisor, Quality Management Liaison, Data Analyst Programmer, Credentialed Staff Associated with Definitions (categories) selected. For example, case managers, physicians, etc.
- An organizational chart depicting the agency as a whole and the proposed staff and functions affiliated with this proposal.

- A description of the process and coordination of program and fiscal staff in ensuring adequate reporting, reconciliation, and tracking of expenditures for the proposed Ryan White project.
- A description how the proposed Ryan White project's staffing plan will demonstrate cultural and linguistic competence through clearly defined values, behaviors, attitudes, policies, structures, and practices, as well as through the employment of bilingual and bi-cultural staff at all levels of the agency.
- A description of the applicant's policy and procedures for employee orientation and in-service training.
- A description of the applicant's policy and procedures for ensuring that required professional licenses are current and on file.

This section must not exceed 3 pages in length. The applicant must complete the Detail of Personnel Form (See Attachment D) for each category of service applied for. The applicant must include the curriculum vitae or resume and job descriptions for key program staff, including the Project Director and Chief Financial Officer and, if applicable, the Medical Director. Place the Detail of Personnel Form and the curriculum vitae or resumes and job descriptions for key program staff as an Appendix in the application.

CORPORATE EXPERIENCE

The Contractor must have the corporate resources necessary to support the successful outcome of this contract. The contractor selected will have the requisite experience and resources to carry out the activities detailed in this Request. More specifically, the successful contractor:

- Must be an organization that meets the competence and independence requirements set forth in 42 CFR 438.354

SECTION 5: COST PROPOSAL

Detailed Budget and Budget Narrative:

Applicants must provide a proposed budget and budget justification for each year of the 3-year project period for each service category for which funds are requested for each year (1 July 2014- 30 June 2015, 1 July 2015- 30 March 2016, and 1 July 2016- 30 June 2017). Please note that applicants must provide a documented and verifiable 10% match of the total project cost in non-federal funds in each year. Include the source of funds for the match (e.g. development funds) and a description of how the match is being used to support Part B program activities (e.g. 5% of a case manager FTE).

Line-Item Budget Proposals

A line item budget proposal form is provided as a part of this RFP (See Attachment C). The applicant is strongly recommended to use this form provided. However, if the applicant opts to use another form or format, the applicant must ensure that all requested information is present.

Provide a narrative in the budget form provided (or equivalent form) that explains the amounts requested for each line item in the budget. The budget justification must specifically describe how each item will support the achievement of proposed objectives. Applicants must estimate the number of clients to be served and the total estimated costs for each service category for which funds are requested. Line item information must be provided to explain the costs.

Each applicant is required to have an accounting system in place that adequately tracks Part B clients/patients in real time throughout the grant year. Applicants will be reviewed on this fact and if agencies are not able to distinguish Part B clients/patients and funds used to support them, immediate disqualification of the application may result. Similarly, for agencies receiving other “Part” funds for Ryan White, they must prove their accounting system can differentiate clients/patients and the services they receive.

Pay particular attention to how each item in the “other” category is justified. The budget justification must be concise yet articulate all matters pertaining to the budget request.

Include the following in the budget justification narrative on the budget form provided (or equivalent form):

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percent full time equivalency, hourly wages, and annual salary.

Fringe Benefits: List the components that comprise the fringe benefit rate, for example EOHHS insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated to the project.

Travel: List travel costs according to local travel. For local travel, the mileage rate, number of miles, reason for travel, and staff member completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops relevant to the project. The mileage rate requested for in-state travel cannot exceed the state mileage rate for in-state travel (currently, \$0.56 per mile).

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the project’s goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of \$5,000 and a useful life of one or more years).

Supplies: List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are blood tubes, plastic gloves, etc. and educational supplies may be pamphlets and educational videotapes.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost in the category. In some cases, rent, utilities, insurance, and other administrative costs fall under this category if they are not included in an approved indirect cost rate.

Administrative/Indirect Costs: Indirect costs are those costs incurred for common or joint objectives that cannot be readily identified but are necessary to the operations of the organization (e.g. the cost of operating and maintaining facilities, depreciation, and administrative salaries).

The inclusion of indirect costs (capped at 10%) is allowable only where the applicant has a current certified negotiated rate approved by HRSA using the Certificate of Cost Allocation Plan or Certificate of Indirect Costs. For agencies wishing to include an indirect cost rate, documentation of a current Certificate of Cost Allocation Plan or Certificate of Indirect Costs signed by an individual at a level no less than the Chief Financial Officer of the agency that submits the proposal or component covered by the proposal must be included as an Appendix in the application.

If an applicant does not have an indirect cost rate that meets HRSA requirements, the applicant may wish to obtain one through the U.S. Department of EOHHS & Human Services' Division of Cost Allocation (DCA). Visit DCA's website at <http://rates.psc.gov/> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

Agencies that do not have a current certified negotiated rate approved by HRSA must request costs that they would have categorized as indirect costs (and other administrative costs requested) as direct line-item administrative costs. Applicants requesting direct line-item administrative costs must provide supporting documentation on how they arrive at the costs. These costs would most likely be included in the "other" line item. Please note that EOHHS is required by HRSA to meet a 10% aggregate administrative cost cap for contracted direct services. The aggregate cost cap includes indirect costs.

For all case management applicants (non-medical and medical case management) - applicants must estimate the number of medical/non-medical case management clients to be served, the number of service units and hours to be provided, and the estimated total cost. The budget justification must specifically describe how these services will support the achievement of proposed objectives.

Vendors are expected to coordinate between Part B, other Ryan White funded services (e.g., Part C, D and SPNS), and third party payers who are ultimately responsible to pay the cost of services provided to eligible or covered persons. In some cases other Ryan White "Parts" may pay for different services than Part B. It is acceptable for a client to accept and be offered a variety of services under Ryan White. It is, however the agency's responsibility to document eligibility for a Part B service and to be clear that Part B is not assuming the burden of costs that can be billed to other "Parts."

Third party sources include Medicaid, Children’s EOHHS Insurance Programs (SCHIP), Medicare (including the Part B prescription benefit), and private insurance (The Indian Health Service is exempt from the payer of last report provision). Vendors providing Medicaid-eligible services must be Medicaid-certified. Ryan White Part B funds are payer of last report funds and vendors must make every effort to ensure that alternative sources of payment are pursued and that program income is used consistent with grant requirements.

Ryan White Program legislation requires vendors to collect and report 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. Program income is gross income – earned by a vendor under a grant – directly generated by the grant-supported activity or earned as a result of the award. Program income includes, but is not limited to, income from fees for services performed (e.g. direct payment, or reimbursement received from Medicaid, Medicare, and third party insurance), and income a vendor earns as a result of a benefit made possible by receipt of a grant or grant funds.

Direct payments include charges imposed by vendors for Part B services such as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges. Program income must be added to funds committed to the project or program and used to further eligible project or program objectives. Program income is subject to cost principles. Vendors are responsible for having systems in place to account for program income and for monitoring to ensure that program income is tracked and used consistent with grant requirements (See <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf>)

Applicants must also provide a narrative that describes the following:

- Supporting documentation on how administrative costs were determined.
- The process that will be used by the applicant to monitor third party reimbursement,
- How the applicant will document that clients have been screened for and enrolled in eligible programs such as Medicare, Medicaid, private EOHHS insurance, or other programs to ensure that Ryan white HIV/AIDS Program funds are the payer of last resort.
- How the applicant will monitor the appropriate tracking, use, and reporting of any program income, and
- Client eligibility criteria for clients who are supported with Ryan White HIV/AIDS Part B Program services by proposed service category (e.g. outpatient/ambulatory medical care, non-medical case management services, oral EOHHS care, emergency financial services, etc.).

Section V: Budget Narrative must not exceed 4 pages in length per category applied for. Include the Budget Narrative section behind the completed budget form in the application. The budget form itself is exempt from the page limit for the Budget Narrative.

SECTION 6: EVALUATION AND SELECTION

Applicants must use the entry checklist found as Attachment L. EOHHS will disqualify a proposal at this point if it does not meet the basic requirements set forth in the entry

checklist. Proposals that pass the entry review will then be evaluated by a Proposal Review Committee composed of state government personnel.

The potential maximum score a proposal may receive is 100 points. In order to be considering “passing” and the potential to be funded, a proposal must receive at least 70 points across the categories listed below.

EOHHS reserves the exclusive right to select the individual(s) or firm (vendor) that it deems to be in its best interest to accomplish the project as specified herein; and conversely, reserves the right not to fund any proposal(s).

Proposals will be reviewed and scored based upon the following criteria:

Criteria	Possible Points
Section IV: Part 1 – Cover Page & Letter, Table of Contents	5 Points
Section IV: Part 2 – Project Narrative	20 Points
Section IV: Part 3 – Agency Qualifications and Experience	15 Points
Section IV: Part 4 – Work Plan	30 Points
Section IV: Part 5 – Staffing Plan	15 Points
Section V: Cost Proposal	15 Points
Total Possible Points	100 Points

Points will be assigned based on the offeror’s clear demonstration of his/her abilities to complete the work, apply appropriate methods to complete the work, create innovative solutions and quality of past performance in similar projects.

Applicants may be required to submit additional written information or be asked to make an oral presentation before the technical review committee to clarify statements made in their proposal.

To summarize, a Proposal Review Committee will evaluate proposals competitively for adherence to the intent of the RFP and federal and state Ryan White Part B requirements, as well as how well the proposal will provide increased access to the treatment cascade/HIV continuum of care for minority PLWH/A address unmet need and reduce the number of persons out of care, ensure geographic parity in access to HIV/AIDS services throughout the state, meet the needs of any emerging populations, ensure that PLWH/A remain engaged in HIV/AIDS primary medical care and adhere to HIV treatment, ensure that resource allocations for services to women, infants, children, and youth are in proportion to the percentage of the state’s disease cases represented by each population, relate to the goals of Healthy People 2020. The committee shall also be educated in the National HIV/AIDS Strategy (NHAS), the equity considerations of the proposal, the Early Identification and Intervention of People Living with HIV/AIDS (EIIHA) plan, and the overall elements associated with HRSA requirements. Applicants must have a complete understanding as to these components and reviewers shall be judging the extent by which applicants adhere to these areas.

A major factor of consideration will be on how all proposals will contribute to accomplishing the following federal and state expectations for PLWH/A in Rhode Island:

- Ensure the availability and quality of all core medical services within the state,
- Eliminate disparities in access to core medical and support services for PLWH/A among disproportionately affected subpopulations and historically underserved communities,
- Identify individuals who know their HIV status, but who are not in care, informing them about available treatment and services, and assisting them in the use of those services,
- Address the primary EOHHS care and treatment needs of those who know their HIV status but who are not in care, as well as the needs of those currently in care,
- Identify individuals who are unaware of their status and making them aware of their status, informing them about available treatment and services, and assisting them in the use of those services, and
- Provides goals, objectives, timelines, and appropriate allocation of funds (as determined by needs assessment).
- To the maximum extent possible, address the top five services identified by consumers in EOHHS's 2011 needs assessment as being services they "needed but could not get" Meets Ryan White cost effectiveness, coordination, and payer-of-last resort requirements.

The applicant with the total highest score will be considered first for possible funding within the category specifically being reviewed based on the Review Committee's evaluation and assigned scores, a recommendation for tentative awards will be made to the Chief Fiscal Officer of EOHHS, the Medicaid Director and Secretary of Health and Human Services. The Review Team will submit the rank-ordered recommendations, comments and score to these individuals for final approval. Once approved, EOHHS staff will begin negotiations with the recommended applicants to finalize the contractual agreements.

Applicants are required to use the entry checklist form provided with the application package (see Attachment L), which may be included as a finished checked copy with the application. Applicants must place this checklist on top of the original proposal as a means of revealing their compliance with the RFP.

SECTION 7: PROPOSAL SUBMISSION

Proposal Submission and Content

Applicants must use a standard 12-point Times New Roman font on 8 ½ X 11 inch paper. The entire proposal must be typed in black ink on white paper. Applications may be bound with a metal clip or elastic band, but cannot be stapled or permanently bound. Margins on all sides must be one inch and single line spacing is required. The narrative must be typed on one side of each page and the applicant's name must appear on each page. The entire application, including appendices, must be sequentially page numbered. The application sequence must be as follows: Section I. Cover Page, and Table of Contents, II. Project Narrative, III. Agency Qualifications and Experience, IV. Workplan/Goals and Objectives,

V. Staffing Plan, VI. Budget/Justification, and Appendices. These are further described in detail below.

Please Note: There must be a distinct and separate Project Narrative, Budget line items/narrative, Workplan, Staffing Plan for EACH service category for which funds are requested. Applicants may submit one application for different service categories, providing the sections are clearly marked and reviewers are able to distinguish categories applied for.

Questions concerning this solicitation may be e-mailed to the HIV Provision of Care Program (Medicaid Division, EOHHS) at Christopher.Botelho@ohhs.ri.gov no later than the date and time indicated on page one of this solicitation. Please reference **RFP # HIVRW14-1** on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Ryan White RFP page (<http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/Adults/RyanWhiteHIVCareProgram/RequestforProposals.aspx>) as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

No other contact with State parties will be permitted. Interested offerors may submit proposals to provide the services covered by this Request on or before the date and time listed on the cover page of this solicitation. Responses received after this date and time, as registered by the official time clock in the reception area of EOHHS will not be considered.

Responses (**an original, seven (7) hard copies, and one (1) electronic copy on a flash drive**) should be hand-delivered in a sealed envelope marked “**RFP# HIVRW14-1**” to:

RI EOHHS
Medicaid Division: HIV Provision of Care, Garden Level
74 West Road
Cranston, RI 02920

NOTE: Proposals received after the above-referenced due date and time will not be considered. Proposals misdirected to other State locations or those not presented to the HIV Provision of Care program by the scheduled due date and time will be determined to be late and will not be considered. Proposals faxed or emailed to EOHHS will not be considered. The official time clock will be based upon atomic time and a clock will be located at EOHHS in staff locations at the Garden Level. When you arrive at the Hazard Building (74 West Road, Cranston, RI 02920) please call Christopher Botelho at 401-462-3517 or Garlete Parker at 401-462-3520 and they will meet you , time stamp your proposal, and provide you with a receipt. If you do not make the time/date provisions set herein, your proposal will be denied and not accepted.

RESPONSE CONTENTS

Responses shall include the following:

1. A completed and signed four-page R.I.V.I.P generated bidder certification cover sheet downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.
2. A completed and signed W-9 downloaded from the RI Division of Purchases Internet home page

at www.purchasing.ri.gov.

3. **A separate Technical Proposal** describing the qualifications and background of the applicant and experience with similar programs, as well as the work plan or approach proposed for this requirement.
4. **A separate, signed and sealed Cost Proposal** reflecting the hourly rate, or other fee structure, proposed to complete all of the requirements of this project.
5. In addition to the multiple hard copies of proposals required, respondents are requested to provide their proposal in **electronic format (flash drive)**. Microsoft Word / Excel OR PDF format is preferable. One (1) electronic copy are requested and should be identical to the original hard copy submission. In any variance between the hard copy and electronic file, the original copy takes precedence.

CORPORATE RESPONSIBILITIES

The following are the major responsibilities of the Contractor and the State of Rhode Island:

- Multiple Awards – A variety of contracts will be awarded.
- Conditions Governing Subcontracting – If the Contractor intends to use any subcontractors, the Contractor must clearly identify the subcontractor in the response to the RFP. The Contractor retains responsibility for the completion and quality of any work assigned to subcontractors. The Contractor is expected to supervise the activities of subcontractors and employees in order to ensure quality. A Memorandum of Agreement is a necessary component of this RFP for all subcontractors.
- **Compliance with Statutory, Regulatory and Other Standards:** The Contractor must comply with all applicable State and Federal regulations and statutes.
- **Confidentiality and Protection of Public Health Information and Related Data:** The Contractor shall be required to execute a Business Associate Data Use Agreement, and any like agreement, that may be necessary from time to time, and when appropriate. The Business Associate Agreement, among other requirements, shall require the successful bidder to comply with 45 CFR 164.502(e), 164.504(e), 164.410, governing Protected Health Information (“PHI”) and Business Associates under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 USC Section 1320d, et seq., and regulations promulgated there-under, and as amended from time to time, the Health Information Technology for Economic and Clinical Health Act (HITECH) and its implementing regulations, and regulations promulgated there-under, and as amended from time to time, the Rhode Island Confidentiality of Health Care Information Act, R.I. General Laws, Section 5-37.3 et seq. The successful Bidder shall be required to ensure, in writing, that any agent, including a subcontractor, to whom it provides Protected Health Information

received from or created or received by and/or through this contract, agrees to the same restrictions and conditions that apply through the above-described Agreements with respect to such information. Any information provided by the Department to the Contractor for the completion of the project may not be sold, given or otherwise shared with outside parties.

Notwithstanding the above, the State reserves the right not to award this contract or to award on the basis of cost alone, to accept or reject any or all proposals, and to award in its best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

The State may, at its sole option, elect to require presentation(s) by offerors clearly in consideration for award.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded to the RFP. The State's General Conditions of Purchases/General Terms and Conditions can be found at the following URL: <https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf>